

**Mental Health Intensive Case Management (MHICM)
in the Department of Veterans Affairs:
The Ninth National Performance Monitoring Report -
FY 2005**

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Executive Summary

This is the ninth national report on the evaluation of the Department of Veterans Affairs Mental Health Intensive Case Management (MHICM) program, previously called “Intensive Psychiatric Community Care” or “IPCC”. MHICM is an innovative, experimentally validated approach to care for veterans with severe and persistent mental illness that has been endorsed by VHA Directive 2006-004 and the Strategic Mental Health Plan. Previous reports (Rosenheck et al., 1997; Neale et al., 1998-2005) have demonstrated that: 1) assertive community treatment is a cost-effective service for veterans with serious mental illness who are high users of VA inpatient resources; 2) MHICM benefits are maintained over the long-term (2-5 years); and 3) MHICM can be implemented and monitored in VA settings nationally. This report, which presents performance data for FY 2005 refers to early efforts and evaluations as “IPCC” and recent teams and data as “MHICM”.

The MHICM Program

VHA Directive 2000-034 (revised as VHA Directive 2006-004) defines “Mental Health Intensive Case Management” and identified criteria for client entry, program operation and monitoring. MHICM teams seek to deliver high quality services that: 1) provide intensive, flexible community support; 2) improve health status (reduce psychiatric symptoms & substance abuse); 3) reduce psychiatric inpatient hospital use and dependency; 4) improve community adjustment, functioning, and quality of life; 5) enhance satisfaction with services; and 6) reduce treatment costs.

Extensive literature demonstrating that assertive community treatment (ACT) or intensive case management teams can improve clinical status and reduce psychiatric hospital use for people with serious mental illness has prompted researchers, practitioners and advocates to identify ACT as an essential evidence-based practice for this population (Drake et al., 2001, Phillips et al., 2001). MHICM teams modeled on ACT provide individualized services in the community for veterans with serious mental illness. MHICM services are organized around a core set of treatment elements: 1) Intensity of contact; 2) Flexibility and community orientation; 3) Rehabilitation focus; and 4) Continuity and responsibility. A revised directive was issued on January 30, 2006.

Dissemination and Team Structure

FY 2005 ended with 92 MHICM teams in operation and at least eight more in development. VHA Directive 2006-004 specifies MHICM performance and outcome monitoring by the Northeast Program Evaluation Center (NEPEC), VA Connecticut Healthcare System. Data are presented here for 5,696 veterans who received MHICM services in FY 2005 from 84 teams with 10 or more clients that collected outcome data for the period. Of this group, 4,985 veterans (88%) had entry interview data, 3,466 (61%) had follow-up interview data, and 4,341 (77%) had clinical progress report data. Another 407 veterans entered MHICM from pre-existing case management programs, with a lower standard of client monitoring. The number of MHICM teams (+110%) and clients (+171%) has increased significantly since 1997 while program cost per client (\$7,052) and client-to-staff ratio (+1%; 12.4 per FTE) remained stable. Almost 42% of teams had fewer than 4.0 clinical FTE, the standard set forth in VHA Directive 2006-004 and 23% had staff detailed to other services (16%).

Client Characteristics

Overall, 89% of MHICM veterans had a diagnosis of psychotic illness at entry and had spent an average of 75 days in the hospital in the previous year. About two fifths of MHICM clients (41%)

had been hospitalized for *more than two years* in their lives, with over two decades of illness since their first hospital stay. Virtually all MHICM clients (94%) received VA and/or Social Security funds for their disability. Most (56%) received VA compensation for a service-connected disability and almost half (46%) had a representative payee manage their funds. Clearly, this group of veterans is dealing with long-term illness and severe disability. Client characteristics have remained fairly stable since 1997, though pre-admission hospital days have declined by 45%, following overall VA trends.

Service Delivery

Altogether 90% of MHICM veterans were seen weekly or more frequently by MHICM team staff; 63% were seen for more than one hour per week; and 90% received the majority of their care in the community. MHICM clients had an average of 71 face-to-face contacts with MHICM staff during FY 2005 or 1.4 face-to-face visits per veteran weekly. A total of 729 veterans (13%) were discharged from the program during the year and 159 veterans (3%) were transitioned to less intensive services after meeting criteria specified in VHA Directive 2006-004. On average, MHICM veterans had received services for 1,295 days or more than 3 1/2 years.

Outcomes

Veterans treated by MHICM teams showed average reductions in psychiatric hospital days of 29 days (72%) during their first six months in the program and proportionate reductions through 12, 18, and 24 month periods, all statistically significant. All but two teams reduced hospital use for all time periods. Outcome analyses found statistically significant improvements of 13% on clinician-rated symptoms (BPRS mean change: -5.45, $t=-18.34$, $p<0.0001$) and 14% on client-reported symptom severity scores (mean change: -0.24, $t=-19.01$, $p<0.0001$). Client-reported housing independence increased by 13% (mean change: +0.41, $t=18.56$, $p<0.0001$) and quality of life improved by 10% (mean change: +2.62, $t=21.37$, $p<0.0001$). MHICM veterans were significantly more satisfied with MHICM services relative to standard VA mental health care (+18%; mean change: +0.56, $t=25.66$, $p<0.0001$). This was reflected in higher satisfaction with overall VA mental health services at follow-up (+11%; mean change: +0.32, $t=13.00$, $p<0.0001$). FY 2005 client outcomes were comparable to FY 2004 levels and consistently higher (+25% to +225%) than 1997 values.

Adherence to Model Standards

Review of team reports and outlier values supports continued monitoring of team resources and performance and attention to staff training needs. VHA Directive 2000-034 established guidelines for MHICM team operation that have been translated into a set of minimum standards and monitored to identify performance outliers. Twenty-nine of eighty-four MHICM teams (35%) met all eight minimum program standards in FY 2005, comparable with 18 teams (25%) in FY 2004. A new network performance measure and continuous monitoring feedback for network leaders continue to reinforce an initiative begun in 2001 to expand the implementation of MHICM nationwide.

Conclusion

Development of MHICM in VHA has followed a model sequence of problem identification, program development, evaluation and dissemination (Rosenheck and Neale, 2001; Rosenheck, 2001). Careful implementation and sustained monitoring have resulted in effective community-based services for veterans with serious mental illness, a highly vulnerable population. MHICM has been successfully disseminated to more than 90 facilities and site-by-site monitoring data show it continues to provide effective and efficient services to several thousand deserving veterans in great need.

Acknowledgments

We dedicate this Ninth National Performance Monitoring Report to the men and women who have served in Operations Enduring Freedom and Iraqi Freedom and their families for their sacrifice and, in particular, to those with serious mental illness who have yet to benefit from community-based services. At this stage in history, the stigma of mental illness still discourages individuals from seeking help. Few veterans or family members are likely to read this report, review program data with MHICM team members, participate in service delivery or evaluation, or provide feedback that affects program operation. We hope that will change with implementation of the Mental Health Strategic Plan, as veterans and family members are invited to become partners through advisory groups and participate in evaluation, planning and service delivery in ways that reshape the nature of VHA and MHICM services.

This report and the successful dissemination of MHICM owe much to ongoing support from Ira Katz MD, Deputy Chief of Patient Care Services for Mental Health; Mark Shelhorse MD, outgoing Acting Chief Consultant; and William Van Stone MD, Chief, Treatment Services Division and Coordinator for SMI Veterans Program, for the Office of Mental Health Services (OMHS) in Washington, DC; members of the Committee on Care of Veterans with Serious Mental Illness (SMI Committee) and its Consumer Council; and Paul Errera MD, who continues to advocate for community-based services for veterans with serious mental illness.

Implementation of MHICM teams within VA has also benefited from efforts on behalf of assertive community treatment by individuals in the public sector, including: William Knoedler MD, Deborah Allness MSSW, Mary Ann Test PhD and the Program for Assertive Community Treatment in Madison, Wisconsin; Cheri Sixbey CSW and the Assertive Community Treatment Association; Neil Meisler MSW and Alberto Santos MD from the Medical University of South Carolina; Fred Frese PhD, Elizabeth Edgar RN, Dottie Sayer, Bonnie Banks, June Judge, Jane Fyer, Moe Armstrong, Tom Shade, Mary Gibson and the Veterans Committee from the National Alliance on Mental Illness; and the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration (SAMHSA).

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Acronyms

ACCESS	MICROSOFT OFFICE RELATIONAL DATABASE SOFTWARE
ACT	ASSERTIVE COMMUNITY TREATMENT (PROGRAM MODEL)
ADJ	ADJUSTED SCORE
AVG/MN	AVERAGE
ARC	ALLOCATION RESOURCE CENTER
BPRS	BRIEF PSYCHIATRIC RATING SCALE
BSI	BRIEF SYMPTOM INVENTORY
CM	CASE MANAGEMENT OR CASE MANAGER
CPR	CLINICAL PROGRESS REPORT FORM (NEPEC MONITORING FORM 39)
DSS	DECISION SUPPORT SYSTEM (VHA FISCAL SOFTWARE)
DX	DIAGNOSIS
FDF	FOLLOW-UP DATA FORM (NEPEC MONITORING FORM 37)
FTE	FULL TIME EQUIVALENT POSITION
FY	FISCAL YEAR
GAF	GLOBAL ASSESSMENT OF FUNCTIONING SCORE
GM+S	GENERAL MEDICINE AND SURGERY FACILITY
GTE	GREATER THAN OR EQUAL TO
HOU1	HOUSING INDEPENDENCE INDEX
IADL	INSTRUMENTAL ACTIVITIES OF DAILY LIVING
IDF	INITIAL DATA FORM (NEPEC MONITORING FORM 34)
IDF DATE	INITIAL DATA FORM DATE
IP	INPATIENT
MAX	MAXIMUM
MD	PHYSICIAN, PSYCHIATRIST
MH	MENTAL HEALTH
MHICM	MENTAL HEALTH INTENSIVE CASE MANAGEMENT (PROGRAM)
MIN	MINIMUM
NEPEC	NORTHEAST PROGRAM EVALUATION CENTER (WEST HAVEN, CONNECTICUT)
NP	FORMER NEUROPSYCHIATRIC FACILITY
NSC	NON-SERVICE-CONNECTED
OMHS	OFFICE OF MENTAL HEALTH SERVICES
OPC	OUTPATIENT CLINIC FILE (VHA OUTPATIENT AUTOMATED DATA, AUSTIN TX)
OQP	OFFICE OF QUALITY AND PERFORMANCE
PTF	PATIENT TREATMENT FILE (VHA INPATIENT AUTOMATED DATA, AUSTIN TX)
PRE-ENTRY	PERIOD BEFORE ADMISSION TO MHICM
QOL	QUALITY OF LIFE SCALE
RN	NURSE
SAS	STATISTICAL ANALYSIS SYSTEM SOFTWARE
SC	SERVICE-CONNECTED
SMI	SERIOUS MENTAL ILLNESS
SMITREC	SERIOUS MENTAL ILLNESS TREATMENT RESEARCH EVALUATION CENTER
SSI	SOCIAL SECURITY SUPPLEMENTAL INCOME
SSDI	SOCIAL SECURITY DISABILITY INCOME
TX	TREATMENT
YR	YEAR
VERA	VETERANS EQUITABLE RESOURCE ALLOCATION (VA BUDGETING STRUCTURE)
VHA	VETERANS HEALTH ADMINISTRATION
VHACO	VETERANS HEALTH ADMINISTRATION CENTRAL OFFICE
VISN	VETERANS INTEGRATED SERVICE NETWORK (MULTI-SITE HEALTH SYSTEM)
VSSC	VHA SUPPORT SERVICE CENTER

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Chapter One: Mental Health Intensive Case Management in a Changing VA Health Care System

Changes in VA Mental Health Care

The closing years of the twentieth century confronted the Department of Veterans Affairs (VA) and other public mental health systems with the challenge of providing appropriate, humane and efficient care to people with serious mental illness. Despite closing 40,000 psychiatric hospital beds between 1957 and 1988, VA relied heavily on inpatient treatment through the 1990's, spending over 70% of its mental health budget on hospital care as recently as FY 1996 (Rosenheck, 1997).

In 1995, the Veterans Health Administration (VHA) began to fundamentally reorganize its structure and services toward a more comprehensive, integrated healthcare system with enhanced priorities of customer satisfaction, cost efficiency and accountability. Manifestations of change have included: introducing data-based approaches to care and management; decentralizing administrative and budget authority to 21 veterans integrated service networks (VISNs); reallocating healthcare resources; and reorienting care from inpatient to outpatient, community-based and electronic services.

In 2003, the President's New Freedom Commission on Mental Health (2003) called for a transformation of mental health service systems to better incorporate consumer and family input and improve access to evidence-based practices, including assertive community treatment, articulated in the Federal Action Agenda (Transforming Mental Health in America, 2005). VA's Action Agenda (Achieving the Promise, 2003) and Mental Health Strategic Plan (2004; 2005) incorporated Mental Health Intensive Case Management (MHICM) services into efforts to expand the continuum of care and ensure access to quality mental health care. As outlined in the Strategic Plan, the Office of Mental Health Services and the Office of Quality and Performance implemented a performance measure in 2005 to increase the number of MHICM teams and staff nationally. A revised MHICM directive, VHA Directive 2006-004, was issued on January 30, 2006.

Organizational changes in mental health services have prompted dramatic reductions in VA inpatient service use. Between Fiscal Years 1995 and 2005, general psychiatry inpatient lengths of stay declined 63% (from 32 to 12 days) and 6,253 general psychiatry beds (69% of the 1995 total) were closed, including 1,507 (86%) long-stay beds (Greenberg & Rosenheck, 2006). Inpatient mental health expenditures accounted for 35% of VA mental health expenditures in FY 2005 (\$0.9B) versus 54% in FY 2004 (\$1.2B). A VHA accounting shift from the Cost Distribution Report to the Decision Support System in FY 2005 limits comparability of direct costs with prior years. Inpatient resources continued to decline, with 247 general psychiatry beds closed, though bed reductions were partially offset by significant growth in outpatient and residential rehabilitation services. Between 1995 and 2005, the number of veterans receiving VA outpatient mental health care rose by 357,694 (+65%) while outpatient contacts per treated veteran fell from 15 to 11 (-26%). Unadjusted for inflation, mental health expenditures rose by \$173M (+9%) through FY 2004. FY 2005 data show a stronger increase (\$642M; +32%). Mental health expenditures as a percentage of VA clinical costs fell from 16% in FY 1995 to 12% (-23.2%) in FY 2005 (Rosenheck, 1996; Greenberg & Rosenheck, 2006).

The shift from inpatient to outpatient mental health care in VA would be expected to have its greatest impact on veterans with the most severely disabling mental illnesses, who traditionally have relied on long-term hospital treatment and may be least able to tolerate rapid change. People with serious mental illness are among the “least well off” (Rosenheck et al., 1998) and most vulnerable to homelessness, substance abuse, profound social isolation and vocational dysfunction (Grob, 1994). Ethicists (Callahan, 1995; Boyle, 1995) and service researchers (Rosenheck, 1999; Schlesinger, 1995; Schlesinger and Mechanic, 1993) have urged us to recognize core values in our society and not neglect the most vulnerable citizens and to recognize that their vulnerability earns them special claim on public resources. Ethical and societal goals warrant careful attention to developing and monitoring quality mental health services, particularly for veterans who are most needy.

Accountability and Monitoring

VA healthcare increasingly emphasizes value, customer service, and accountability and provides specific impetus for implementation and careful monitoring of community-based services (Kizer, 1998). VA values clearly underscore the need for alternatives to inpatient hospitalization and enhanced attention to accountability and customer satisfaction. The Veterans Eligibility Reform Act of 1996 (Public Law 104-262, Section 104) committed VA to maintain capacity of specialized services for the most vulnerable veterans and mandated review of leadership reports on capacity by the VA Under Secretary for Health’s Special Committee for the Care of Severely Chronically Mentally Ill Veterans (the “SMI Committee”). In 1999, the Under Secretary approved an SMI committee recommendation to improve access to intensive case management programs such as IPCC by veterans with serious mental illness (Recommendation 3, SMI Committee, 1999). VHA Directive 2000-034 (newly revised as 2006-004) defines “Mental Health Intensive Case Management” services for veterans with serious mental illnesses. MHICM implementation is monitored through an OQP performance measure under guidance from the Comprehensive Mental Health Strategic Plan.

Case Management and Assertive Community Treatment (ACT)

For several decades, mental health clinicians and researchers, dismayed by the adverse consequences of precipitous State Hospital closures during the 1960's and 1970's, have sought to develop humane, health-promoting alternatives to long term hospital care for severely mentally ill persons in community settings. Case management services have emerged as a widely preferred alternative to fragmented outpatient care in which a specialist facilitates access to and coordinates delivery of the full range of services needed by people with severe mental illness. General, or broker model, case management has been used for a variety of purposes that range from cost cutting to improving clinical outcomes and has only limited research support for its effectiveness. **Assertive community treatment (ACT)**, a model of integrated, intensive and comprehensive services provided by a team of skilled clinical case managers in community settings, offers a more supportive approach for individuals with serious mental illness that has been carefully developed and evaluated.

ACT was first implemented as the Program of Assertive Community Treatment (PACT) in Madison, Wisconsin over 25 years ago and evaluated in a landmark series of experimental studies (Marx et al, 1973; Stein et al., 1975; Stein and Test, 1980a, 1980b; Weisbrod et al., 1980). ACT providers meet their clients in the community and share responsibility for providing comprehensive services including social support, skills training and medical care, wherever and whenever they are

most needed (Allness and Knoedler, 2003; Stein and Santos, 1998). A team of up to 15 case managers offers individualized community care, replacing the custodial functions of an institution with personal support and therapeutic skills training in natural settings.¹

ACT Replication and Research

In the early 1980's, the success of the Madison PACT studies began to influence public policy. Wisconsin shifted inpatient treatment funds toward community-based services and Michigan funded Harbinger, the first replication of the PACT experiment (Mowbray et al., 1997; Mulder, 1985). By 1987, ACT principles had been adapted in demonstrations by numerous municipal and state mental health care systems, including Chicago, Philadelphia, Ohio and New York (Test, 1992; Olfson, 1990; Burns and Santos, 1995; Deci et al., 1995). Replications varied with respect to the breadth and intensity of services, the accessibility and training of staff, and their effectiveness (Olfson, 1990; Stein, 1990; Deci et al., 1995; Essock and Kontos, 1995). Over the next ten years, at least 14 states developed ACT initiatives (Allness et al., 1997; Meisler, 1997). Rhode Island, Delaware and Texas established ACT as a standard "best practice" and required state-funded providers of services for the seriously mentally ill to develop ACT team services for their most troubled clients. In 1998, the Schizophrenia Patient Outcomes Research Team (PORT) highlighted ACT's effectiveness and relatively limited dissemination in its findings (Lehman et al., 1998). A year later, the National Alliance for the Mentally Ill (NAMI) made state funding for ACT services a central element of its anti-stigma advocacy campaign (NAMI, 1999). By 2004, most states reported the presence of an ACT team or active legislative/lobbying effort, with some (e.g., Florida, Illinois, Indiana, New Jersey, Virginia) funding multi-site state ACT initiatives (NAMI, 2004). Outside the United States, ACT has been adopted in Canada, Europe and around the world (Burns et al., 2001). Recent comparison of VA and non-VA treatments for schizophrenia found that VA clients were less likely to receive case management services (Rosenheck et al., 2001).

Experimental studies published over 20 years have reported that concentrating treatment resources in community-based ACT teams or intensive case management programs can result in improved clinical status of severely mentally ill patients at no additional cost (Bond et al., 1989; Hoult et al., 1984; Mulder, 1985; Stein and Test, 1980; Wasylenki et al., 1985; Weisbrod, Stein and Test, 1980). Other studies, however, have found case management to be associated with no clinical change and/or increased service utilization and cost (Bond et al., 1991; Curtis et al., 1992; Drake et al., 1998; Essock et al., 1998; Franklin et al., 1987; McFarlane et al., 1992). Literature reviews have concluded that intensive community treatment frequently reduces hospital use but does not always achieve net cost-savings or clinical improvement (Burns and Santos, 1995; Mueser, 1998; Olfson, 1992; Scott and Dixon, 1995). Most recent reviews have identified assertive community treatment as a clinically effective "evidence-based practice" when implemented correctly which can be cost-effective for clients who are high users of inpatient services (Phillips et al., 2001). A Cochrane Review concluded that ACT clients were more likely to stay in treatment and out of the hospital, to

¹ A typical PACT team is staffed with a multi-disciplinary group of 10-15 clinicians who are configured to provide a comprehensive array of clinical and rehabilitation services every day (including evenings, weekends, holidays) and ensure 24 hour per day access for needed crisis intervention (Allness and Knoedler, 2003). A typical ACT team has 5-8 clinicians who, by necessity, provide less comprehensive services for fewer hours per week and rely on emergency/admitting staff or others to consult them about off-hour crises.

live more independently, and to be more satisfied with care than clients who received standard community or case management services (Marshall and Lockwood, 2002).

VA Demonstration: MHI, IPCC

VA initiated a demonstration program of intensive case management teams based on ACT principles at ten northeastern VA medical centers in 1987. Originally a regional demonstration (the Region 1 Mental Health Initiatives or MHI), VA's adaptation of assertive community treatment became known as Intensive Psychiatric Community Care (IPCC). A rigorous experimental study of this effort demonstrated the cost-effectiveness of this approach in VA (Rosenheck et al., 1995; Rosenheck and Neale, 1998a). IPCC, while developed for the most troubled high hospital users, was based on flexible operation guidelines that may be applied, with modifications, to other patient populations. Studies have shown that effective program performance requires adherence to the treatment model supported by training and performance monitoring (Rosenheck and Neale, 2001).

MHICM (formerly IPCC) Program Objectives and Principles

MHICM services are delivered by integrated, multidisciplinary teams and based on the Substance Abuse Mental Health Services Administration (SAMHSA) ACT standards. MHICM teams seek to deliver high quality services that:

- provide intensive, flexible community support;
- improve health status (reduce psychiatric symptoms & substance abuse);
- reduce psychiatric inpatient hospital use and dependency;
- improve community adjustment, functioning and quality of life;
- enhance satisfaction with services; and
- reduce treatment costs.

To accomplish these objectives, MHICM teams adhere to four core treatment elements, most recently outlined in VHA Directive 2006-004:

- Intensity of Contact. High intensity of care (typically two to three contacts per week) primarily through home and community visits, with low caseloads (seven to fifteen veterans per clinical full-time equivalent employee), allowing rapid attention to crisis, and the development of community-living skills to prevent crisis in this exceptionally vulnerable population.
- Flexibility and Community Orientation. Flexibility and community orientation with most services provided in community settings and involving integration with natural support systems whenever possible (e.g., family members, landlords, employer).
- Rehabilitation Focus. Focus on rehabilitation through practical problem solving, crisis resolution, adaptive skill building and transition to self-care and independent living where possible.
- Continuity and Responsibility. Identification of the team as a “fixed point of clinical responsibility” providing continuity of care for each veteran, wherever the veteran happens to

be, for at least one year, with subsequent care subject to review of continuing need for intensive services.

Demonstration Findings

Analysis of data from the original multi-site MHI demonstration project yielded evidence that assertive community treatment principles could be adapted successfully within the VA healthcare system, that community-based treatment approaches could be effective in reducing hospital use and costs and improving clinical status, and that positive outcomes could be sustained or enhanced over extended time periods. Two-year demonstration findings (Rosenheck and Neale, 1998a) confirmed previous experimental research by showing significant reductions in hospital use and costs, and improvements in psychiatric status and social functioning, for veterans receiving IPCC services (Burns and Santos, 1995; Olfson, 1989; Scott and Dixon, 1995). Overall, average health care costs were \$4,860 (13%) less per patient per year for those treated in IPCC. The demonstration also illustrated the value of program monitoring that addresses facility and client characteristics, administrative mission and support, and model fidelity, all of which can substantially influence program development and impact (Rosenheck and Neale, 1998b; 2001).

Program Performance Monitoring

The resource intensity of IPCC services and the program's novelty for VA have warranted collection of data on client status, service delivery and utilization, and clinical and cost outcomes, through a national monitoring and evaluation system developed and managed by VA's Northeast Program Evaluation Center (NEPEC). Integration and feedback of national data have reinforced program accountability and maintained performance standards that have been shown in the scientific literature to be essential to program effectiveness.

The 1997 IPCC Report: 1) reviewed findings from a two-year experimental design evaluation of IPCC in VA; 2) presented extended follow-up data addressing long-term clinical and cost impact on a subset of patients whose progress was followed for up to five years; 3) described a novel training and performance monitoring program developed at the Northeast Program Evaluation Center (NEPEC) for dissemination of this model; and 4) summarized initial performance data from the program's national dissemination through March 31, 1997 (Rosenheck et al., 1997). Successive reports summarized program developments and performance data for veterans treated in Fiscal years 1998 through 2001 (Neale et al., 1999-2002). The present (eighth) report summarizes performance monitors and outliers for 4,761 veterans treated by 71 teams during FY 2004.

MHICM Directive and Network Implementation Plans

VHA Directive 2006-004 (originally 2000-034 and enclosed as **Appendix A**) describes an initiative to establish **Mental Health Intensive Case Management (MHICM)** teams throughout VHA, based on the established evidence-based practice of Assertive Community Treatment (ACT) (Phillips et al, 2001). IPCC, ACT and other intensive case management services that met standards of service intensity and access were renamed as **MHICM**. The Directive defined the target population, standards and monitoring procedures for MHICM services. Shortly thereafter, VHA headquarters initiated a process through which each VISN would submit a detailed plan evaluating

the need for MHICM in their network and describing specific steps to implement appropriate services. This initiative was the result of recommendations made by the Under Secretary for Health's Special Committee on the Treatment of Severely Mentally Ill Veterans (known as the SMI Special Committee) to assure appropriate community care would be available for veterans in the face of substantially reduced inpatient capacity. When many of the initial network plans lacked sufficient detail, the request was reissued with additional guidance and specific response templates, with responses due at the end of September 2001. To increase awareness of veterans who met MHICM admission criteria, an inpatient screening performance measure was instituted in 2002. In 2004, as part of the Federal Action Agenda to implement the New Freedom Commission recommendations, VHA implemented the Comprehensive Mental Health Strategic Plan which included expansion of MHICM services.

Team Development

In 1997, VA facilities and Veterans Integrated Service Networks (VISN) began to express interest in implementing MHICM teams for veterans with serious mental illness or co-occurring mental illness and substance abuse disorders. Where feasible, NEPEC staff provided assistance in the form of information, material, linkage and technical support for sites with various levels of commitment to implementation of the model. To assist local leaders with planning and decision-making about community-based intensive case management services, NEPEC developed an Implementation Planning Packet in 1999. The packet contained descriptive materials and literature about MHICM, a brief bibliography, an outline of minimum program standards and expectations, and implementation/fidelity checklists addressing essential elements of MHICM and assertive community treatment. It is useful for planning a new MHICM team or comparing the structure of an existing case management team to the model. An updated version of this material, included as **Appendix B** in the MHICM report, is available with MHICM monitoring forms at NEPEC web pages on VA intranet (<http://vaww.nepec.mentalhealth.med.va.gov>) and public internet (<http://www.nepec.med.va.gov>).

MHICM Capacity Performance Measure

In FY 2005, under guidance from the Strategic Mental Health Plan, the Office of Quality and Performance (OQP) implemented a national performance measure to support development of MHICM teams to meet the needs of veterans with serious mental illness. The measure involves a population index, 4% of veterans with a diagnosis of psychosis, derived from the Psychosis Registry, maintained by the Serious Mental Illness Treatment and Research Evaluation Center (SMITREC) in Ann Arbor, Michigan. Facilities with 60 or more veterans on the index are expected to have a MHICM team with at least 4.0 “on the street” case managers and clinical and administrative supports and to provide staffing to the level required by the population index (a client-to-staff ratio of about 15:1). For each facility, FY 2005 targets were established at 60% and 77% of the population index value. Veterans with 3 or more MHICM stop codes during a given month were counted as service recipients. The MHICM Capacity performance measure is described in the VHA Performance Measurement System Technical Manual available for download on the OQP intranet web site: <http://vaww.oqp.med.va.gov/>. Monthly facility scores, generated from the Austin, Texas Patient Care database, are available at: http://klfmenu.med.va.gov/WORKLOAD/MHICM_NEW.ASP. Quarterly facility and network scores are available through the OQP Executive Briefing book, at: <http://vaww.pdw.med.va.gov/pdwframe.asp>.

References

- Allness D, Detrick A, Neale M, Plum T, Olsen MC, Rutkowski P. (1997). P/ACT dissemination and implementation from three states and the Department of Veterans Affairs. *Community Support Network News*, 11 (4): 8-9.
- Allness DJ & Knoedler WH. (2003). *A Manual for ACT Start-Up*. Waldorf, MD: National Alliance for the Mentally Ill. (www.nami.org).
- Bond GR, McDonel EC, Miller LD. (1991). Assertive community treatment and reference groups: an evaluation of their effectiveness for young adults with serious mental illness and substance abuse problems. *Psychosocial Rehabilitation Journal*, 15: 31-43.
- Bond GR, Miller LD, Krumwied RD, Ward RS. (1989). Assertive case management in three CMHCs: A controlled study. *Hospital and Community Psychiatry*, 39: 411-418.
- Boyle P. (1995). Minds and hearts: Priorities in mental health services. In PJ Boyle and D Callahan (Eds.) *What Price Mental Health?* Washington, DC: Georgetown University Press, 3-44.
- Burns BJ, Santos AB. (1995). Assertive community treatment: An update of randomized trials. *Psychiatric Services*, 46: 669-675.
- Burns T, Fioritti A, Holloway F, Malm U, Rossler W. (2001). Case management and assertive community treatment in Europe. *Psychiatric Services*, 52: 631-6.
- Callahan D. (1995). Setting mental health priorities: problems and possibilities. In PJ Boyle and D Callahan (Eds.) *What Price Mental Health?* Washington, DC: Georgetown University Press, 175-192.
- Committee on Care of Severely Chronically Mentally Ill Veterans. (1999). *Third annual report to the under secretary for health*. Washington, DC: Mental Health Strategic Healthcare Group.
- Curtis JL, Millman EJ, Streuning E, D'Ercole A. (1992). Effect of case management on rehospitalization and utilization of ambulatory care services. *Hospital and Community Psychiatry*, 43: 895-899.
- Deci PA, Santos AB, Hiott W, Schoenwald S, Dias JK. (1995). Dissemination of assertive community treatment programs. *Psychiatric Services*, 46: 676-678.
- Drake RE, McHugo GJ, Clark RE, Teague GB, Xie H, Miles K, Ackerson T. (1998). Assertive community treatment for patients with co-occurring severe mental illness and substance abuse disorder: A clinical trial. *American Journal of Orthopsychiatry*, 68: 201-215.
- Essock SM, Frisman LK, Kontos NJ. (1998). Cost-effectiveness of assertive community treatment teams. *American Journal of Orthopsychiatry*, 68: 179-190.
- Essock SM, Kontos N. (1995). Implementing assertive community treatment teams. *Psychiatric Services*, 46:679-683.

Franklin J, Solovitz B, Mason M, Clemons JR, Miller GE. (1987). An evaluation of case management. *American Journal of Public Health*, 77: 674-678.

Greenberg G, Rosenheck RA. (2002). National mental health program performance monitoring system: Fiscal year 2002 report. West Haven, CT: Northeast Program Evaluation Center.

Grob GN. (1994). *The Mad Among Us*. New York: Free Press.

Kizer K. (1995). Under Secretary for Health, US Department of Veterans Affairs. *Vision for change*. Washington DC: US Department of Veterans Affairs, Veterans Health Administration.

Kizer K. (1996). Under Secretary for Health, US Department of Veterans Affairs. *Prescription for change*. Washington DC: US Department of Veterans Affairs, Veterans Health Administration.

Kizer K. (1998). Under Secretary for Health, US Department of Veterans Affairs. *Journey of change*. Washington DC: US Department of Veterans Affairs, Veterans Health Administration.

Lehman AF, Steinwachs DM, Co-investigators of the PORT project (1998). Translating research into practice: The schizophrenia patient outcomes research team (PORT) treatment recommendations. *Schizophrenia Bulletin*, 24(1): 1-10.

Lehman AF, Kreyenbuhl J, Buchanan R, Dickerson F, Dixon L, Goldberg R, Green-Paden L, Tenhula W, Boerescu D, Tek C, Sandson N, Steinwachs D: The Schizophrenia Patient Outcomes Research Team (PORT): Updated Treatment Recommendations 2003, *Schizophrenia Bulletin*, 30 (2):193-217, 2004.

Marshall M, Lockwood A. Assertive community treatment for people with severe mental disorders (Cochrane Review), *The Cochrane Library*, Issue 3, 2002. Oxford: Update Software.

Marx AJ, Test MA, Stein LI. (1973). Extrahospital management of severe mental illness. *Archives of General Psychiatry*, 29: 505-511.

McFarlane WR, Stastny P, Deakins S. (1992). Family-aided assertive community treatment: a comprehensive rehabilitation and intensive case management approach for persons with schizophrenic disorders. San Francisco, CA: Jossey-Bass: *New Directions for Mental Health Services*, 53: 43-54.

Meisler N. (1997). Assertive community treatment initiatives: Results from a survey of selected state mental health authorities. *Community Support Network News*, 11 (4): 3-5.

Mowbray C, Collins M, Plum T, Masterton T, Mulder R. (1997). Harbinger I: The development and evaluation of the first PACT replication. *Administration and Policy in Mental Health*, 25: 105-123.

Mowbray C, Plum T, Masterton T. (1997). Harbinger II: Deployment and evolution of assertive community treatment in Michigan. *Administration and Policy in Mental Health*, 25: 125-139.

Mueser KT, Bond GR, Drake RE et al: Models of community care for severe mental illness: A review of research on case management. *Schizophrenia Bulletin* 24(1):37-74, 1998.

Mulder R. (1985). Evaluation of the Harbinger program, 1982-1985. Lansing, MI: Michigan Department of Mental Health.

National Alliance for the Mentally Ill (NAMI). (1999). The PACT Advocacy Guide. Arlington, VA: NAMI and www.nami.org.

National Alliance for the Mentally Ill (NAMI). (2000). State-by-State Availability of PACT Model Programs. Arlington, VA: NAMI and <http://www.nami.org/about/pact.htm>.

Neale MS, Rosenheck RA, Baldino R., Cavallaro L. (2000). Intensive psychiatric community care (IPCC) in the department of veterans affairs: The third national performance monitoring report, FY 1999. West Haven, CT: VA Northeast Program Evaluation Center Report.

Neale MS, Rosenheck RA, Baldino R., Cavallaro L. (1999). Intensive psychiatric community care (IPCC) in the department of veterans affairs: The second national performance monitoring report, FY 1998. West Haven, CT: VA Northeast Program Evaluation Center Report.

Neale MS, Rosenheck RA, Castrodonatti J, Martin A, Morrissey J, Anderson J. (2005). Mental health intensive case management (MHICM) in the department of veterans affairs: The eighth national performance monitoring report–FY 2004. West Haven, CT: VA Northeast Program Evaluation Center Report (www.nepec.med.va.gov).

Neale MS, Rosenheck RA, Castrodonatti J, Martin A, Morrissey J, Anderson J. (2004). Mental health intensive case management (MHICM) in the department of veterans affairs: The seventh national performance monitoring report–FY 2003. West Haven, CT: VA Northeast Program Evaluation Center Report (www.nepec.med.va.gov).

Neale MS, Rosenheck RA, Hogu T, Martin A. (2001). Mental health intensive case management (MHICM) in the department of veterans affairs: The fourth national performance monitoring report – FY 2000. West Haven, CT: VA Northeast Program Evaluation Center Report.

Neale MS, Rosenheck RA, Hogu T, Martin A. (2002). Mental health intensive case management (MHICM) in the department of veterans affairs: The fifth national performance monitoring report – FY 2001. West Haven, CT: VA Northeast Program Evaluation Center Report.

Neale MS, Rosenheck RA, Martin A, Morrissey J, Castrodonatti J. (2003). Mental health intensive case management (MHICM) in the department of veterans affairs: The sixth national performance monitoring report – FY 2002. West Haven, CT: VA Northeast Program Evaluation Center Report.

New Freedom Commission on Mental Health. (2003). Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD.

Olfson M. (1990). Assertive community treatment: An evaluation of the experimental evidence. *Hospital and Community Psychiatry*, 41: 634-641.

Phillips SD, Burns BJ, Edgar ER, Mueser KT, Linkins KW, Rosenheck RA, Drake RE, McDonell Herr EC. (2001). Moving assertive community treatment into standard practice. *Psychiatric Services*, 52: 771-9.

Rosenheck RA. (1997). National mental health program performance monitoring system: Fiscal year 1996 report, West Haven, CT: Northeast Program Evaluation Center.

Rosenheck RA. (1999). Principles for priority setting in mental health services and their implications for the least well off. *Psychiatric Services*, 50: 653-658.

Rosenheck RA. (2001). Organizational process: A missing link between research and practice. *Psychiatric Services*, 52: 1627-1632.

Rosenheck R, Armstrong M, Callahan D, Dea R, Del Vecchio P, Flynn L, Fox RC, Goldman HH, Horvath T, Munoz R. (1998). Obligation to the least well off in setting mental health service priorities: A consensus statement. *Psychiatric Services*, 49: 1273-4, 1290.

Rosenheck RA, Desai R, Steinwachs D, Lehman A. (2000). Benchmarking treatment of schizophrenia: A comparison of service delivery by national government and by state and local providers. *Journal of Nervous and Mental Disorders*, 188: 209-16.

Rosenheck RA, Neale MS. (1998a). Cost-effectiveness of intensive psychiatric community care for high users of inpatient services. *Archives of General Psychiatry*, 55: 459-466.

Rosenheck RA, Neale MS. (1998b). Inter-site variation in impact of intensive psychiatric community care on hospital use. *American Journal of Orthopsychiatry*, 68: 191-200.

Rosenheck RA, Neale MS. (2001). Development, implementation and monitoring of intensive psychiatric community care in the department of veterans affairs. In B. Dickey and L. Sederer (Eds.), *Achieving quality in psychiatric and substance abuse practice: Concepts and case reports*. Washington, DC: American Psychiatric Publishing.

Rosenheck RA, Neale MS, Baldino R, Cavallaro L. (1997). Intensive psychiatric community care (IPCC): Dissemination of a new approach to care for veterans with serious mental illness in the department of veterans affairs. West Haven, CT: VA Northeast Program Evaluation Center Report.

Rosenheck R, Neale M, Leaf P, Milstein R, Frisman L. (1995). Multisite experimental cost study of intensive psychiatric community care. *Schizophrenia Bulletin*, 21: 129-140.

Stein LI, Santos AB. (1998). *Assertive community treatment of persons with severe mental illness*. New York: Norton.

Schlesinger M. (1995). Ethical issues in policy advocacy. *Health Affairs*, 14 (3): 23-29.

Schlesinger M, Mechanic D. (1993). Challenges for managed competition from chronic illness. *Health Affairs*, 12 (supplement): 123-137.

Scott JE, Dixon LB. (1995). Assertive community treatment and case management for schizophrenia. *Schizophrenia Bulletin*, 21: 657-668.

Stein LI. (1990). Comments by Leonard Stein. *Hospital and Community Psychiatry*, 41:649-651.

Stein LI, Test MA. (1980). Alternative to mental hospital treatment I: Conceptual model, treatment program and clinical evaluation. *Archives of General Psychiatry*, 37: 392-397.

Stein LI, Test MA, Marx AJ. (1975). Alternative to the hospital: A controlled study. *American Journal of Psychiatry*, 132: 517-522.

Test, MA. (1992). The Training in Community Living model. In R.P. Liberman (ed.), *Handbook of psychiatric rehabilitation*. New York: Macmillan, 153-170.

Test MA, Stein LI. (1980). Alternative to mental hospital treatment III: Social cost. *Archives of General Psychiatry*, 409-412.

Under Secretary for Health, US Department of Veterans Affairs. (1996). VHA Directive 96-051 (August 14, 1996). *Veterans Health Administration Special Emphasis Programs*. Washington DC: US Department of Veterans Affairs, Veterans Health Administration.

Under Secretary for Health, US Department of Veterans Affairs. (2006). VHA Directive 2006-004 (January 30, 2006). *VHA Mental Health Intensive Case Management*. Washington DC: US Department of Veterans Affairs, Veterans Health Administration.

U.S. Congress. (1996). Veterans eligibility reform act of 1996. Public Law 104-262, Section 104.

Veterans Health Administration. (2000). VHA Mental Health Intensive Case Management (MHICM). Directive 2000-034. U.S. Department of Veterans Affairs.

Wasylenki DA, Goering PN, Lancee WJ, Ballantyne R, Farkas M. (1985). Impact of a case manager program on psychiatric aftercare. *Journal of Nervous and Mental Disease*, 173:303-308.

Weisbrod BA, Test MA, Stein LI. (1980). Alternative to mental hospital treatment II: Economic benefit-cost analysis. *Archives of General Psychiatry*, 37:400-405.

Intranet Documents:

Achieving the Promise: Transforming Mental Health Care in VA. The Department of Veterans Affairs Action Agenda. http://vaww.mentalhealth.med.va.gov/mh_transformation.shtm

VHA Mental Health Strategic Plan (2005).
ftp://vaww.mentalhealth.med.va.gov/main/vha_mh_strategic_plan.pdf

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Chapter Two: National Assessment of MHICM Program Performance

VA Implementation of IPCC/MHICM

In 1993, responding to Congressional hearings and requests to enhance the priority of care for seriously mentally ill veterans within VA, the Director of Mental Health and Behavioral Sciences Service (Paul Errera, M.D.) submitted a “National Initiative for Seriously Mentally Ill Veterans” that featured the dissemination of Intensive Psychiatric Community Care (IPCC) programs. The VA National Planning Board approved the plan and Acting Under Secretary for Health agreed to provide \$1.5 million in FY 1994 and \$10 million in FY 1995 to establish new IPCC programs. The initial plan included additional funds for FY 1996 and FY 1997. VA Medical Centers and freestanding Outpatient Clinics were eligible to apply for IPCC funds, involving several levels of review.

Between 1993 and 1995, IPCC teams were implemented at 30 additional sites around the country using national funds, with one quarter of available resources allocated to each of the four existing regions. On the basis of detailed implementation and outcome data from the original MHI demonstration, a standard resource package was designed to support operation of IPCC teams. This package consisted of \$325,000 for 6.25 FTE; \$15,000 in All Other funds; and \$30,000 (10% of personnel) for medical center administrative costs, for a total of \$370,000 recurring. Seventeen sites were awarded the standard package and six sites were funded at lower levels (3.5 FTE; \$200,000 PS; \$15,000 AO; \$20,000 OH) due to lower number of eligible veterans or rural location.

In support of the national dissemination, teams at Brockton, Canandaigua, Montrose and West Haven each received 1.0 FTE to allow experienced staff to act as mentor-monitors for 6-8 new teams. Over a two-year period, mentor teams participated in various planning and training activities that included: a 2-day planning meeting; weekly conference calls; four orientation and training sessions with clusters of teams; site visits; and ongoing formal and informal communication via mail, e-mail, fax and telephone. Staff from each new program site attended a 1-day orientation and training session with NEPEC staff, mentors and other programs, then accompanied mentor staff to their home facility for several days of direct observation and training. Calls were held weekly or biweekly for 6-12 months and then tapered depending upon team status. All new teams maintained formal contact with their mentors for at least one year after orientation and training.

In addition to regular contacts with new program sites, mentor-monitors reviewed each team’s progress via planning conference calls with NEPEC staff and other mentor-monitors (weekly: July 1994 to June 1996; quarterly: July 1996 to September 1997). Mentors also completed implementation checklists at six months and one year, reviewing with each team details of its configuration and operation. Finally, staff from each mentor team conducted at least one site visit of a FY 1994 program after nine to twelve months of operation. Site visits enabled mentors to observe the team when it was fully operational and to help the team resolve implementation difficulties.

Recent Implementation

In 1997, as VHA decentralized resource management, individual facilities and Veterans Integrated Service Networks (VISNs) began to request NEPEC consultation, training and technical assistance to implement MHICM teams. In subsequent years, teams were started with local resources in Detroit (MI), Central Iowa, Milwaukee (WI), St. Cloud (MN), Lyons (NJ) and the Rocky Mountain Network (VISN 19), and with network resources in VA Healthcare System of Ohio (VISN 10) and the South Central VA Healthcare Network (VISN 16). Many other sites requested information and consultation, and some facilities implemented case management teams that varied in structure and intensity of services without NEPEC assistance. VHA Directive 2000-034 prompted additional requests for consultation and training, and a network planning process described in Chapter One. To meet the training needs of new teams, NEPEC staff routinely request that network leaders provide support for team participation in face-to-face orientation and training, mentoring by a successful team and attendance at annual meetings of the Assertive Community Treatment Association (ACTA) or the United States Psychiatric Rehabilitation Association (USPRA, formerly IAPSRs),

Monitoring of the Bronx team was discontinued in 2000 after consultation revealed the program no longer operated within MHICM standards. Staff were reassigned to more traditional clinical and case management services. Mountain Home, Salisbury and Spokane teams merged with other programs, substantially impacting staff resources, caseloads, program fidelity and outcomes. More recent efforts to rejuvenate clinical operations at Salisbury have been successful.

MHICM National Program Monitoring

National monitoring of MHICM program performance, specified in VHA Directive 2006-004, relies on: client interviews, clinician and team progress reports, and centralized VA databases. Sources of data include: (1) Monthly FTE / Caseload reports monitoring program productivity, workload, staff turnover and admissions; (2) Structured clinical interviews with each veteran at entry (Initial Data Form-IDF) and (semi-) annually thereafter (Follow-up Data Form-FDF) addressing client characteristics, clinical status, functioning and service use; (3) (Semi-)Annual clinical progress reports of MHICM services and outcomes, completed by the veteran's primary case manager; (4) VA automated inpatient and outpatient service use data; (5) Fidelity assessments of team conformity with MHICM and ACT program guidelines; and (6) Staffing and budget summaries completed for an annual site progress report. Evaluation forms have been abbreviated to reduce paperwork demands.

MHICM program evaluation and monitoring variables target four domains following the classic formulation of Donabedian (1980): 1) **Program structure**: utilization and configuration of allocated resources and caseload levels; 2) **Client characteristics**: socio-demographic, disability level and clinical status at entry; 3) **Program Process**: pattern of service delivery, therapeutic activities and alliance, and readmissions; and 4) **Outcomes**: client use of hospital services, symptoms, functioning, quality of life and satisfaction with services.

The following section of the report presents data on each monitoring domain, from client interviews, clinician progress reports and automated databases, for veterans with follow-up data between October 1, 2004 and September 30, 2005. **Table 2-1** lists 47 current MHICM program monitors, indicating for each its relevant domain and program objective, the table in which its data

are presented in this report and whether it is a “critical” program monitor (see below). Monitoring data are summarized in 33 tables and 6 figures. **Appendix D** summarizes the source and creation of all variables included in performance monitoring tables for this report. All MHICM teams participate in national performance monitoring, including the use of specific DSS identifiers (552, 546, 567) for clinical workload. Programs providing less intensive case management services exclusively are not monitored but workload is reported under DSS identifier 564. In FY 2001, VHA revised the Veterans Equitable Resource Allocation (VERA) reimbursement structure by adding veterans with 41 or more MHICM (552) visits in a year to those for whom networks receive higher reimbursement. For FY 2005, the potential reimbursement difference was about \$29,846 per veteran.

Monitoring Team Performance

Premises on Which the Monitoring System is Based. MHICM is still a relatively new clinical activity in VA, requiring considerable freedom for clinical innovation. Monitoring efforts are based on the assumption that rigid regulations or performance standards might stifle the creative evolution of the model and fail to account for local variation. At the same time, since VA and non-VA studies show that poor implementation is associated with low cost-effectiveness (Rosenheck and Neale, 1998b; Mueser et al., 1998; Phillips et al., 2001), it is important to monitor the program as completely and objectively as possible, identifying performance standards as suggested by research. Through this monitoring system we have sought to assemble a body of data that can guide national and network program developers and front line clinicians as they implement MHICM teams in the years ahead.

Critical Monitors: Statistical Norms vs. Practice Standards. Although a complete set of practice standards has not been established for this program, monitoring data allow more than a description of individual site performance and statistical norms have been computed for selected critical monitors. The distinction between statistical norms and formal practice standards is an important one. Practice standards are established by a consensus of professionals as directive guidelines for appropriate clinical practice. They codify how health care should be conducted. Statistical norms, in contrast, reflect how health care is practiced on average without specifying exactly what is or is not acceptable practice. Although some practice standards have been established for the MHICM program through VHA Directive 2006-004, many aspects of the program have yet to be quantitatively standardized. Even in these areas, however, practice variation within the MHICM program can be measured and statistical outliers can be identified. Identification of statistical outliers must not be confused with identification of practice standard violations. Statistical outliers are worthy of attention as extremes on a continuum but, without exploring specific circumstances, one cannot draw conclusions about their exact meaning for program performance at a particular site.

FY 2004 Critical Monitors. Nineteen of forty-seven current MHICM measures identified in Table 2-1 were selected as critical monitors that assess aspects of the program of special importance to fulfilling its mission.² Most of these monitors have clear directionality (i.e. extremely large or small values suggesting a departure from program values and goals). Again, performance monitors should not be considered in isolation as absolute indicators of the quality of care delivered at any site.

²Two monitors from the 1997 Report were dropped from national monitoring when the Readmission Review Form was made optional as part of paperwork reduction effective January 1, 1998. Client symptom and functioning monitors (each comprised of two measures) were separated, with no net change in monitors.

In most cases they can be used to properly identify statistical outliers, the importance of which must be determined by follow-up discussions or visits with the sites.

Identification of Statistical Outlier Sites. For each monitor, site data are presented in tabular form. At the bottom of a column, sums and averages across all veterans (ALL SITES) are presented, along with the mean and standard deviation for teams included in the table (SITE). In the original report, sites were identified as outliers on a variable if the site value was more than one standard deviation from the mean. For subsequent reports, outliers have been identified by a more complex statistical procedure involving **risk adjustment** for differences in baseline characteristics of veterans across sites as well as differences in sample size. First, simple change scores are created for each variable by subtracting Pre- (entry or baseline) values from Post- (latest follow-up) values and computing site means. Second, baseline covariates are standardized by subtracting the overall mean from individual values and computing transformed means. Third, analyses of covariance are run for each outcome, using 13 baseline covariates and 2 time-in-program variables. Least-squares means adjusted for covariates are computed for each site and t-tests are run comparing the adjusted means from each site with the median site value. Sites that differ statistically from the median site (p value <0.05) in the **undesired** direction are identified in Tables 2-6 to 2-25 with a shaded value. Sites that differ significantly from the median in the **desired** direction are identified with a bold underlined value. The performance of outlier sites is significantly different from the median site after adjusting for differences in veteran characteristics at entry and duration of program involvement.

It is important to note that outliers on critical monitors are being identified on a purely statistical basis. This is a more rigorous and conservative approach that, unlike previous use of standard deviations to identify outliers, accounts for site and other differences at baseline, baseline values of the variable in question, and length of time veterans are in the program. For variables where all site values are close together, no outlier may be identified. For variables where site values are skewed, outliers may be identified in one direction but not the other. For variables where site values are normally distributed, a balanced number of outliers may occur in both directions.

Minimum Program Standards

VHA Directive 2006-004 establishes procedural guidelines for MHICM teams that have been operationalized in eight **minimum program standards**. These complement the critical performance monitors. Minimum standards and threshold values include:

- Percent of veterans with psychotic diagnosis at entry (50% or more)
- Percent of veterans with 30 or more psychiatric inpatient days in year before entry (50% or more)
- Mean adjusted face-to-face contacts per week/veteran (1.0 or more)
- Ratio of veterans to clinical FTEE (mean caseload) (7:1 to 15:1)
- Percent of veterans for whom at least 60% of contacts occur in community setting (50% or more)
- Percent of veterans receiving psychiatric rehabilitation or skills training services (25% or more)
- Percent of veterans discharged from MHICM program (< 20%)
- Number of clinical service providers on the team (4.0+ FTEE).

Summary of Outliers. **Table 2-27** summarizes the number of Critical Monitor outlier values identified for each site in four major evaluation domains: program structure, client characteristics, program process and outcome. Critical Monitor outlier values are presented separately by domain in **Tables 2-28 to 2-31**. Outliers for Minimum Program Standards are presented in **Table 2-32**. Negative outlier values are outlined in summary tables. Data were made available to sites for review and discussed on national conference calls. NEPEC program assistants confer with individual sites about specific outlier variables as program evaluation and planning continue during the year.

Team Outlier Review. Prior to publication of this report, MHICM teams were asked to review draft tables and comment on critical monitors where their team value was identified as an outlier in the undesired direction. To facilitate review and comment, draft tables were posted on an intranet web site for direct access by MHICM teams. Outlier review responses are summarized in **Table 2-33**. The outlier review request and form are included in **Appendix C**.

Program Structure

MHICM Sites, Resources and Expenditures

Eight-four of ninety-two MHICM teams that were in operation during FY 2005 and provided follow-up data on ten or more clients are listed in **Table 2-2**, characterized by site type and year of program start-up. Eight developing teams (Durham, Hines, Indianapolis, Loma Linda, Louisville, Memphis, Tennessee Valley and Tucson) had insufficient data to be included in this report. The original MHI demonstration programs began in 1987. Teams at Chicago (West Side), Miami and Portland were begun in 1992 with funds reallocated from three original IPCC teams that were discontinued for incomplete implementation of the program model. Dissemination sites were funded in 1994 and 1995, as part of VA's National Initiative for Veterans with Serious Mental Illness. Four orientation and training sessions were conducted with thirty dissemination sites between August 1994 and July 1995. Subsequent teams (1998 to present) were developed from local or network initiatives.

With decentralization of VA resource management to Veterans Integrated Service Networks (VISNs) in 1996, individual facilities and networks became the locus for funding and implementing new IPCC teams. The first locally funded and nationally monitored IPCC team was initiated by the John D. Dingle VA Medical Center in Detroit, Michigan in 1997. Additional teams were started with network resources by: Healthcare System of Ohio (VISN 10) (1998, 2001, 2005), South Central Healthcare Network (VISN 16) (2001), Mid-Atlantic Healthcare Network (VISN 6) (2002, 2005), Stars and Stripes Healthcare Network (VISN 4) (2003, 2005), VA Southwest Health Care Network (VISN 18) (2003, 2005), VA Heart of Texas Health Care Network (VISN 17) (2003, 2005), Pacific Healthcare Network (VISN 22) (2004), VA Mid-South Healthcare Network (VISN 9) (2005) and VA Sunshine Healthcare Network (VISN 8) and with local resources by: VA Midwest Healthcare Network (VISN 23) (1999, 2002), Rocky Mountain Network (VISN 19) (2000), Capitol Health Care Network (VISN 5) (2003), VA Palo Alto Healthcare System (2002), St. Louis VA Medical Center (2003), Richard L. Roudebush (Indianapolis) VA Medical Center (2005), Edward Hines Jr. VA Hospital (Chicago, 2005) and Southern Arizona VA Health Care System (Tucson, 2005).

In each case, the MHICM Project Director and NEPEC evaluation staff collaborated with an established MHICM ("mentor-monitor") team to provide orientation, training, and ongoing technical

assistance for new team members during start-up. Mentors were assigned to observe team operation and service delivery, and consult on clinical or administrative questions. Regular conference calls were held with members of new teams to support network communication about MHICM and community service needs of veterans with serious mental illness.

VHA resource allocation systems in recent years have diminished historical differences between General Medicine and Surgery (GM&S) and former Neuro-Psychiatry (NP) facilities. To illustrate the influence of facility type on the client population and therapeutic emphasis of individual MHICM teams, we continue to compare client characteristics for the two facility types. As of 2005, the proportion of teams (27 of 84; 32%) and total veterans (2,299 of 5,696; 40%) located at NP sites resembles that of the original study (30% of sites and 40% of veterans) and reflects somewhat higher levels of MHICM-eligible veterans at former NP facilities.

Initial resource allocations to current MHICM sites are enumerated in **Table 2-3**. Resources for early teams are presented in 1988 and 1993 dollars, respectively, and exclude funds for local administrative support as none were provided until 1994. Original programs involved more diverse treatment models and staffing configurations. Initial site resources reported in annual progress reports bring the total funds for MHICM programs in the most recent fiscal year (2005) to almost \$29M, with 91% of funds going to cover personnel costs, and the remainder going to All Other expenses.³ Decentralization of healthcare funding has made it difficult to track original allocations.

MHICM program expenditures for FY 2005, derived from site-generated annual progress reports, are summarized in **Table 2-4**. The data appear to accurately reflect expenditures for program staffing and operation at most sites for the period, although it was impossible to verify program funds merged with other services in mental health service line consolidations. Program expenditures for the 84 MHICM teams in this report totaled \$40.2M during FY 2005, with \$38.6M (96%) expended as Personal Service funds for 480.4 FTEE. Cost data for MHICM teams not included in this report (less than 10 veterans with complete follow-up data) brought the national total to almost \$44M. Average costs were \$478,178 per team, \$80,380 per filled FTE (salary plus benefits) and \$7,052 per veteran client. Unit costs, sensitive to the number of new teams, are provided in Table 2-26.

Table 2-5 presents the assignment and utilization of staff resources through FY 2005. Almost three fifths (49 of 84; 58%) of teams included in this report had 4.0 or more clinical FTE providing clinical services in the community as mandated by VHA Directive 2006-004, consistent with FY 2004 (40 of 71; 56%). Of 35 teams below the clinical FTE standard, 18 (54%) lacked 0.5 FTE, the portion of team leader time accounted for team administration. Community standards for assertive community treatment define the team leader position as equal parts clinical and administrative, to assure the leader time for direct experience with community-based service delivery and participation in administration, supervision, liaison, and personnel management on behalf of the team.

Although most MHICM positions (91%) were filled, 17 teams (20%) had vacancies of more than 6 months as of September 30, 2005, a 35% decrease from FY 2004 (22 of 71, 31%). At the same time, MHICM FTE from 19 teams (23%) were detailed elsewhere without replacement for more

³ In recognition of administrative costs associated with support for an IPCC team, each dissemination site received an increment of 10%, based on Personal Service dollars, for unmonitored administrative use.

than six months, a 46% increase from FY 2004 (11 of 71, 16%). Some personnel gaps were enduring, with vacancies at seven of twenty-two teams (32%) in FY 2004 and five of twenty-nine teams (17%) in FY 2003 still unfilled at the end of FY 2005. Similarly, FTEE detailed away from the MHICM program at ten of eleven teams (91%) in FY 2004 and nine of nineteen teams (47%) in FY 2003 were still detailed away at the end of FY 2005. In sum, despite some improvement, many MHICM teams struggle to retain clinical resources even though the standard mandated by VHA Directive 2006-004 is well below that for assertive community treatment teams in other systems.

On the positive side, some MHICM teams benefited from local and network contributions of additional staff resources. Four of five staff in filled MHICM positions (393 of 480 FTEE or 82%) provided direct clinical services, primarily in community settings. This figure included 0.5 FTEE for team leaders, who were expected to provide a reduced level of community services, but excluded psychiatrists (about 19 FTE) (who generally devoted less than one day per week to MHICM veterans and rarely provided services in the community) and administrative-clerical support staff.

Caseload Levels

Clinical staffing levels and caseloads attained by each program for FY 2005 are shown in **Table 2-6**. Medical Support refers to the assignment of psychiatrists and nurses as members of the multidisciplinary team. Virtually all teams (98%) maintained the active involvement of an assigned nurse and most (68%) had an assigned psychiatrist on the team. Clinical staffing varied considerably across sites, from fewer than 3.0 FTE at Fort Harrison, Philadelphia, St. Cloud, Salem, Sheridan and Tomah to more than 9.0 FTE at Bedford, Canandaigua and Cleveland (including locally contributed resources). Sixty-five teams (77%) maintained client-to staff ratios within the range specified by VHA Directive 2006-004 (7 to 15 clients per clinical FTE), with sixteen teams (19%) **above** the specified maximum (15:1) and three new teams (4%) **below** the specified minimum (7:1) as of September 30, 2005. Combined, the number of in-range teams represents a modest (8%) decline from FY 2004 (59 of 71, 83%). Several teams maintained lower caseload levels or waiting lists to preserve the intensity of their services in the face of persistently unfilled clinical positions.

Client Characteristics

Demographics and Entry Criteria

Socio-demographic characteristics for 5,696 MHICM veterans are presented in **Table 2-7**, for all sites combined (Overall) and by Site Type (GM&S, NP). Current data are comparable to original MHI study values (Rosenheck and Neale, 1998a; Rosenheck et al., 1995), with more Hispanic and African-American veterans, and fewer combat veterans, in the current group. One in five veterans (20%) reported exposure to combat. Few veterans (12.3%) reported paid employment in the three years preceding program entry. Site Type differences are less pronounced than those reported in the original multi-site study, though veterans from former Neuro-Psychiatric facilities are more likely to be male and Caucasian, and less likely to have been married.

Tables 2-8 and 2-9 present Overall, Site Type, and Site data characterizing MHICM veterans at entry. Teams varied in their implementation of MHICM entry criteria. FY 2005 national MHICM program standards called for most veterans to meet the following criteria: 1) primary psychiatric

diagnosis, especially a psychotic disorder; and 2) 30 or more days OR 3 or more stays of VA psychiatric inpatient hospitalization during the year preceding program entry. These criteria were selected and monitored to ensure that resource-intensive MHICM programs targeted veterans with the greatest need for intensive support and the greatest opportunity for VA cost savings. As in the original demonstration, the current overall population of MHICM veterans met target criteria defining veterans with serious mental illness who are high users of VA psychiatric resources. All program participants had a primary DSM-IV psychiatric diagnosis and 73% had been hospitalized for a month or more in the year preceding entry. One in five veterans (20%) was diagnosed with a co-morbid substance abuse disorder. A system-wide decline in length of stay has reduced the proportion of veterans meeting utilization criteria. As a result, current MHICM veterans spent an average of 75 days (± 85 days) in the hospital in the year prior to entering the program, compared with 135 days {a -44% difference} for the 1997 Report (Rosenheck et al., 1997) and 144 days {-48%} for the original demonstration (Rosenheck and Neale, 1998a). Since 1997, the percentage of veterans entering the program directly from a VA psychiatric inpatient unit has fallen sharply, from 98% to 32%, and the proportion of veterans meeting the 30-day hospital use criterion has declined, from 91% to 73%.

Disability Status

Disability income data, presented by site in Table 2-9, reveal extensive VA and Social Security support for psychiatric disabilities among MHICM veterans at entry. More than half of MHICM veterans (N=2,769 of 4,985; 55.4%) reported receipt of VA compensation for a service-connected disability. Of these, 2,028 (73.2%) veterans were service-connected exclusively for a psychiatric disorder, 388 (14.0%) exclusively for a physical disability, and 353 (12.7%) for both. One in six (N=866, 18.4%) veterans reported receiving a non-service-connected disability pension. Many veterans reported receiving Social Security income (SSI: 14.4%; SSDI: 49.4%). Virtually all MHICM veterans (N=4,679; 93.9%) reported receiving some combination of VA and/or Social Security funds, and almost half (46.2%) said a representative payee managed their finances. Although the percentage of MHICM veterans who received VA compensation for service-connected disorders ranged from 33% to 93% across sites, the proportion of veterans receiving some form of disability support was consistently high, between 82% and 100%.

Program Adherence to Entry Criteria

Overall, MHICM teams demonstrated substantial adherence to entry criteria, presented in **Table 2-10**, despite facility differences on specific variables. Most veterans ($72.6\% \pm 20.0\%$ {standard deviation}) met the 30-day criterion for psychiatric hospital use in the year preceding entry. VHA service use data indicate that 83% of MHICM veterans also had 3 or more stays in the previous year. The vast majority of MHICM clients ($88.5\% \pm 9.0\%$) had a psychotic diagnosis (schizophrenia, schizo-affective disorder, other psychosis, bipolar disorder) at entry. One in five veterans ($20.1\% \pm 13.5\%$) had a secondary diagnosis of alcohol or drug abuse. Teams at Albany, Bedford, Danville, Martinsburg and Salem greatly exceeded the national level by targeting veterans with co-occurring diagnoses of mental illness and substance abuse. Two in five MHICM veterans ($41.1\% \pm 15.5\%$) had been hospitalized for two or more years but there was substantial site variation (range: 9.3% to 89.1%). Characteristic of typical onset of psychotic disorder in early adulthood, veterans reported histories of illness spanning more than two decades since their first hospitalization (mean = 22.9 ± 3.0 years; range: 16.6 to 31.0 years).

Measures of clinical status at program entry, shown in **Table 2-11**, indicate levels of client symptoms and functional impairment commensurate with extensive hospitalization and long-term mental illness. Half of MHICM veterans (50.5% \pm 11.8%) reported low-level instrumental functioning on at least one activity of daily life (managing household chores, shopping, finances, medications). Despite accommodations to inpatient life by many veterans prior to entry, clinician ratings of global functioning at program entry were low (GAF mean: 40.4 \pm 5.0) and interviewer ratings of observed symptoms were relatively high (BPRS mean: 40.5 \pm 6.2), reflecting moderate psychiatric impairment. (Note: BPRS ratings were re-scored on a 1-Not Present to 7-Extremely Severe scale to conform with scoring guidelines and current reporting conventions). One in three MHICM clients (32.2% \pm 23.4%) entered the program directly from an inpatient unit in FY 2005 and veterans were more likely to have been discharged or referred by an outpatient service. This extended a clear trend from the first report (when 98% of clients entered directly from the hospital) reflecting dramatic changes in psychiatric lengths of stay within VA since 1997.

Program Process

Program Tenure

MHICM principles emphasize continuity, frequency, intensity, and community-based services for veterans with serious and persistent mental illnesses who have not responded well to traditional modes of treatment. With respect to continuity, MHICM programs are expected to serve as a fixed point of clinical responsibility for their veterans, offering services for at least one year and providing services for as long as clinically necessary. Continuity data in **Table 2-12** indicate that MHICM programs continue to meet this expectation. A modest number (N=729, 12.8%) of MHICM clients (N=5,696) were discharged during the twelve-month report period and 159 veterans (2.8%) were formally transitioned to less intensive services by MHICM team staff per criteria defined by VHA Directive 2006-004. Of 729 veterans discharged from MHICM during FY 2005: 171 (23.5%) left the area; 116 (15.9%) died (93 from natural causes, 6 from self-inflicted injuries, 17 unknown); 110 (15.1%) refused services or requested termination; 103 (14.1%) were admitted to nursing homes or assisted living facilities; 91 (12.4%) graduated or no longer needed services; 50 (6.8%) were “noncompliant”; 11 (1.5%) were incarcerated; 11 (1.5%) exhibited violent behavior; 3 (0.5%) had significant substance abuse; and 63 (8.6%) were discharged for unspecified reasons. On average, veterans in the report (those with follow-up data during Fiscal Year 2005) had been in the program for more than three years (mean=1,295 \pm 616 days) at the time of the latest follow-up interview.

Service Delivery and Alliance

Table 2-13 presents service delivery data provided by MHICM case managers through structured semi-annual case summaries. These data indicate MHICM has been implemented according to principles that have been shown to result in positive outcome (Rosenheck and Neale, 1998a; McGrew et al., 1994). With respect to frequency of contact, 89.9% (\pm 8.2%) of veterans were seen weekly or more and 53.9% (\pm 18.2%) received telephone contacts on a weekly or more frequent basis. Regarding intensity of contact, 62.5% (\pm 17.5%) of veterans were seen for more than an hour per week in the latest six-month period (after about 3 ½ years in the program). Pertaining to location of contact, 90.3% (\pm 9.4%) of veterans received more than 60% of their care in the community. FY 2005 contact levels are within a percentage point higher than FY 2004 values (Neale et al., 2005).

An important aspect of MHICM treatment involves the volume of direct, or face-to-face, contact between staff and clients, recorded as clinic stops in VA's centralized outpatient database, the National Patient Care Database (NPCD). MHICM teams record the bulk of their workload under DSS Identifiers #552 (MHICM Individual Visit), 567 (MHICM Group Visit) and #546 (MHICM Telephone Contact). Overall, as illustrated in **Table 2-14**, each MHICM client had an average of 56 (± 19.3) individual face-to-face visits and 3.2 (± 5.0) telephone contacts with MHICM staff in the year preceding September 30, 2005. Group contacts using the new group code were less common, averaging less than 1 (0.7 ± 2.5) contact per veteran. Nationally the cumulative number of MHICM visits during FY 2005 totaled 398,152 visits, about 1.2 contacts per week per client. Taking into account the portion of the year that clients were enrolled in MHICM (mean = 81% \pm 9%) at each site adjusts the total to about 70 (± 22.3) face-to-face visits for the year or 1.35 visits per week, per client. Including telephone contacts, each veteran received about 75 total contacts, or 1.4 contacts per week, in FY 2005. Since each veteran can receive credit for only one clinic stop per day for a given service, and veterans may have multiple contacts during the day, the data under-represent the actual level of MHICM contact. Overall, FY 2005 MHICM workload was virtually the same as in FY 2004 (1.33 visits / week) and beneath program expectations of 2-3 contacts per veteran per week. The proportion of teams (16 of 84; 19.0%) averaging less than one face-to-face contact per week (the negative outlier value) dropped 33% in FY 2005 from values in FY 2004 (28.2%) and FY 2003 (27.0%).

Table 2-15 depicts the breadth of services provided by MHICM teams to program veterans during FY 2005. Most often, clients received supportive contact (97%), active monitoring (97%), psychotherapeutic interventions (85%), medication management (81%), and medical screening (74%). Less frequently, teams provided crisis intervention (68%), social or recreational activities (65%), housing support (50%) or rehabilitation services (50%). Substance abuse intervention (30%) was generally limited to veterans with specific needs related to dual diagnosis. Vocational support (20%) was the least used service with this severely disabled population. FY 2005 service levels remained stable, within 2% of FY 2004 values.

Clinical case management models stress the importance of the therapeutic relationship between case manager and client, based on frequent and individualized contact, for improving clinical status (Harris and Bergman, 1993; Kanter, 1989). On the basis of earlier retrospective evidence linking therapeutic alliance with MHICM outcomes (Neale and Rosenheck, 1995), case manager-client alliance was monitored at all sites using seven-item versions of the Working Alliance Inventory modified to reflect case management work (Horvath and Greenberg, 1989). **Table 2-16** compares MHICM client perceptions of their current alliance with MHICM case managers at follow-up (Alliance mean: 40.6 ± 3.5) to adjusted ratings of their perceived alliance with previous inpatient / outpatient treaters, reported at entry (Alliance mean: 36.3 ± 2.2). Overall, client ratings of alliance were 12% higher for MHICM staff than for previous treaters, and veterans at 81 (96%) of 84 sites reported higher levels of alliance with MHICM staff.

ACT Model Fidelity

Each MHICM team completed a measure of program fidelity to prescribed elements of assertive community treatment, the Dartmouth Assertive Community Treatment Scale (DACTS; McGrew et al., 1994; Teague et al., 1998). The measure examines team conformity with ACT

program criteria pertaining to human resources, organizational boundaries, service delivery, and substance abuse treatment. Previous research has found that fidelity scores, particularly team factors, correlate strongly with reductions in hospital use (McGrew et al., 1994), and distinguish between effective and ineffective treatment teams (Teague et al., 1995). Results for MHICM programs, displayed in **Table 2-17**, show the teams performed well on three of the four domains [mean scores of 4.0 (human resources), 4.4 (organizational boundaries) and 3.9 (services)]. The fourth domain of the scale pertains to substance abuse treatment, which is not a primary emphasis of MHICM treatment, and results vary significantly by team (mean 3.0, range: 1.0 to 5.0). Although secondary substance abuse diagnoses are present in 20-25% of MHICM veterans at entry, most teams view a primary substance abuse diagnosis as an exclusion criterion. The overall MHICM DACTS score (mean = 4.0 \pm .3) approximates those for other successful public sector ACT teams (Teague et al., 1998), despite including some teams that have shifted MHICM staff to other models of care. More than half (45 of 84, 54%) of MHICM teams achieved a score of 4.0 or more on the ACT Fidelity scale for FY 2005. [Note: VA scores include 23 of 26 original DACTS items. As a result, VA averages may be compared with non-VA programs but VA total scores are lower.]

Distance and Travel Time

For annual Clinical Progress Reports on their work with MHICM veterans, teams estimated the distance and travel time between their office and each veteran's residence. Follow-up reports indicated that most MHICM clients lived within 20 miles (N=2,889; 68.8%) and 30 minutes (N=2,844; 68.3%) of team offices (see **Figures 2-1 and 2-2**). At the same time, sizeable numbers of veterans lived between 21 to 40 miles (N=887; 21.1%) or 30 to 60 minutes (N=1,131; 27.2%) away, and some more than 40 miles (N=426; 10.1%) or 1 hour (N=187; 4.5%) away. The data suggest that MHICM teams have substantially extended access to VA mental health services for veterans with serious mental illness through their outreach activities.

Clinical Outcomes

Reduction in VA Hospital Use

A primary objective of MHICM teams is to reduce veteran reliance on psychiatric inpatient services in favor of more adaptive and less costly treatment alternatives. As evident in **Table 2-18**, this objective was well met, with all teams showing pre- to post-entry reductions in mental health hospital days after six and twelve months. Only two teams (Danville, Grand Junction) showed any increase in hospital use at eighteen and twenty-four months. On average, MHICM veterans (N=4,948) reduced their VA psychiatric hospital use from 40.0 days pre-entry to 11.2 days post-entry (mean reduction = -28.8 \pm 21.9 days) during their first six months in the program. Overall, hospital use reductions of similar magnitude (69-72%) were observed for periods of 12 months (**Table 2-18a**: N=4,351, -45 days), 18 months (**Table 2-18b**: N=3,834, -62 days), and 24 months (**Table 2-18c**: N=3,319, -89 days).⁴ About half of the teams (44 of 84; 52%) had average reductions of 30 or more

⁴ Paired t-tests revealed overall reductions in VA mental health hospital days to be statistically significant at 6 months (N=4,853, mean difference=-29.39, t=-42.72, p<0.0001), 12 months (N=4,297, mean difference=-45.97, t=-36.01, p<0.0001), 18 months (N=3,484, mean difference=-63.55, t=-30.62, p<0.0001), and 24 months (N=3,309, mean difference=-81.41, t=-29.07, p<0.0001).

days per client after one year. As in the original demonstration (Rosenheck and Neale, 1998a), NP teams continue to show greater reductions and cost savings relative to GM&S teams, although GM&S teams have been consistently effective in recent implementations. Hospital use reductions for teams at Northport, Hampton, Salem, Salisbury, Atlanta, Tuscaloosa, Northern Indiana and Tomah were diminished somewhat because some clients with few recent hospital days were “grandfathered” into MHICM from a pre-existing case management program.

One estimate of inpatient cost reductions associated with MHICM entry can be obtained by multiplying the mean reduction in hospital days by the national average hospital per diem rate (FY 2005 inpatient psychiatry per diem = \$852) (Greenberg and Rosenheck, 2005). This method yields estimated inpatient cost reductions, per client, of \$24,456 at 6 months, \$38,486 at 12 months, \$52,444 at 18 months, and \$68,509 at 24 months, unadjusted for inflation. FY 2005 values are lower than in recent years, reflecting a change in the VHA accounting structure from the Cost Distribution Report (CDR) to the Decision Support System (DSS). Although some reduction in hospital use is certainly attributable to expected client improvements over time and course of illness and to system-wide reductions in hospital use, present data suggest substantial cost reductions for veterans with serious mental illness who receive MHICM services.

Improvement in Clinical Status

Consistent with the MHICM mission and objectives, monitored outcomes include improvements in health status, community functioning, and quality of life, as well as customer satisfaction. Outcome measures include ratings of:

- Symptoms by clinician: Brief Psychiatric Rating Scale {BPRS}, Overall and Gorham, 1962;
- Symptoms by client: Symptom Severity {GSI}, Derogatis and Spencer, 1982);
- Global functioning by clinician: Global Assessment of Functioning {GAF}, American Psychiatric Association, 1995, Endicott et al., 1976;
- Instrumental functioning by client: Instrumental Activities of Daily Living {IADL}, Fischer et al., 1996);
- Quality of life by client: Lehman Quality of Life Inventory {QOL}, Lehman, 1988); and
- Satisfaction with VA mental health {VAMHSAT} and MHICM services {MHICM SAT} by client.

For each outcome measure, scores at program entry were compared with scores for the latest 6-month follow-up period in the report window (October 1, 2004 to September 30, 2005). Individual scores were adjusted for fifteen covariates including client characteristics, baseline values, and time in program. Median time in MHICM was 43 months. Data are presented in Tables 2-19 to 2-25.

Case manager ratings of 18 observed symptoms (BPRS) for MHICM clients, summarized in **Table 2-19**, showed an overall reduction of 12.9% from entry (N=4,930, mean sum: 40.5±6.2) to follow-up (mean sum: 35.3±10.2). Observed symptoms decreased at 68 of 84 sites (81%). Client ratings of severity for 30 symptoms on a 4-point scale (GSI: 1-not at all to 4-a great deal) (Fischer et al., 1996), in **Table 2-20**, yielded a similar overall reduction of 13.6% from entry (N=4,802, mean: 1.79±0.19) to follow-up (mean: 1.55±0.31), with lower 6-month ratings at 74 of 84 sites (88%).⁵

⁵Paired t-tests yielded significant differences reflecting improvement in both observed (N=3,076, mean difference: -5.45, t=-18.34, p<0.0001) and reported symptoms (N=2,894, mean difference: -0.24, t=-19.01, p<0.0001).

Reduction in Violent and Suicidal Behavior

MHICM veterans were asked whether they had thought or talked about harming someone, threatened anyone, or actually harmed anyone during their last 30 days in the community. Clients were also asked if they had been arrested or spent a night in jail, for any reason, during the six months preceding the interview. Entry and follow-up responses are presented in **Figure 2-3**. At entry, one in six veterans (N=900, 18.6%) reported thoughts of violence, one in eight (N=620, 12.8%) talked about hurting someone, one in twelve (N=409, 8.4%) threatened someone, and one in thirty (N=155, 3.2%) committed a violent act. At follow-up, levels of violence were much lower across all categories, with 28% fewer veterans reporting violent thoughts (N=441, 13.3%), 41% fewer veterans reporting violent talk (N=252, 7.6%), 48% fewer violent threats (N=145, 4.4%) and 53% fewer violent actions (N=49, 1.5%). The number of veterans reporting arrest (pre: N=464, 9.4%; post: N=79, 2.3%) or jail (pre: N=309, 6.3%; post: 52, 1.5%) also declined, by 75%, at follow-up.

Using similar items, MHICM veterans were asked if they had thought or talked about harming or killing themselves, threatened or attempted suicide in their last 30 days in the community, and if a suicide attempt had resulted in hospitalization for medical reasons (see **Figure 2-4**). Though one in four veterans (N=1,238, 25.5%) reported thinking about suicide prior to entry, and one in six (N=756, 15.5%) had talked about it, fewer veterans had threatened (N=408, 8.4%) or attempted (N=274, 5.6%) suicide. All veterans who attempted suicide were hospitalized for medical reasons. At follow-up, the number of veterans in all of these categories had declined substantially, with fewer reports of suicidal thought (N=366, 11.1%), talk (N=186, 5.6%), threat (N=40, 1.2%), or attempt (N=16, 0.5%). Over a one-year period, 6 (0.01%) of 5,696 veterans targeted in this report died from a completed suicide attempt. Another 110 veterans (1.9%) died from natural (93) or unknown (17) causes.

Indices based on the items described above showed statistically significant reductions in both violence (N=2,947; mean difference: -0.18, $t=-9.13$, $p<0.0001$) and suicidality (N=2,941; mean difference: -0.43, $t=19.35$, $p<0.0001$) for MHICM veterans.

Global and Instrumental Functioning

Case manager ratings of client global functioning (GAF) are presented in **Table 2-21**. VHA adoption of the Global Assessment of Functioning as a national performance monitor for VA mental health in 1998 prompted many facilities to re-train staff in use of the measure, often resulting in a more conservative scoring range. As a result, follow-up GAF scores were lower at many sites (20 of 84 sites, 24%), particularly for established teams with earlier baseline data. Overall means were 3.0% higher at follow-up (mean: 42.6 ± 8.8) than at entry (N=4,888; mean: 40.4 ± 5.0), a statistically significant t-test difference (N=3,549; mean difference: 2.53, $t=13.13$, $p<0.0001$) that is comparable to the 3.5% increase after six months in the first MHICM report (Rosenheck et al., 1997).

Client ratings of performance frequency (1-almost never to 5-almost always) for twelve specific daily skills (IADL), presented in **Table 2-22**, improved slightly (+1.8%) from entry (N=4,256, mean sum: 44.9 ± 3.2) to follow-up (mean sum: 46.2 ± 5.3). Two out of three teams (59 of 84, 70%) showed some level of improvement at follow-up and the overall t-test difference was statistically significant (N=2,330; mean difference: 1.74, $t=0.207$, $p<0.0001$).

Enhanced Quality of Life and Independence

Client ratings on five life satisfaction items (QOL; Lehman, 1988) using a 7-point scale (1-terrible to 7-delighted), reported in **Table 2-23**, indicated improvement (10.1%) from entry (N=4,428, mean sum: 26.1 ± 1.2) to follow-up (mean sum: 29.0 ± 1.8). Clients from all 84 teams (100%) reported higher quality of life after participation in MHICM.⁶

Veterans were asked to indicate the number of nights in their most recent month in the community that they had spent in any of five living situations: a) **independent** (alone or with spouse, family, or friend in apartment or house); b) **minimally restrictive** (supervised apartment, boarding home, adult foster care); c) **moderately restrictive** (halfway house, treatment program, acute psychiatric diversion facility, treatment lodge, domiciliary); d) **extremely restrictive** (psychiatric hospital, skilled nursing facility, jail, or prison); or e) **homeless** (homeless or emergency shelter). In the month preceding their index hospital stay (or program entry), large groups of MHICM veterans reported living in independent (N=2,891, 58.7%), extremely restrictive (N=1,279, 26.2%), or minimally restrictive (N=1,108, 22.6%) residences (see **Figure 2-5**). Fewer veterans reported living in moderately restrictive (N=488, 10.0%) residences or having been homeless (N=217, 4.4%). At follow-up, the numbers of veterans who had been homeless (N=29, 0.9%) or in extremely restrictive residences (N=217, 6.4%) had declined by more than seventy-five percent. There was little change in the proportion of clients who reported living independently (N=1,945, 56.9%) or in moderately restrictive residences (N=251, 7.4%), but fifty-two percent more veterans reported living in minimally restrictive residences (N=1,164, 34.4%). At the same time, client satisfaction with living arrangements and safety increased by 8.1% and 9.1%, respectively. These data reflect the fluidity of living arrangements for veterans with serious mental illness and team reliance on boarding home, foster care and supervised apartments to complement MHICM services in off-hours.

Using the items described above, a housing independence index was created to compare veteran-reported housing status before and after program entry. Client reported days spent at each level of housing independence were multiplied by a corresponding weight (Independent x 4, Minimally restrictive x 3, Moderately restrictive x 2, Extremely restrictive x 1, Homeless x 0). Overall, a comparison of client ratings, presented in **Table 2-23a**, revealed a statistically significant 13.2% gain in housing independence from pre- (N=4,856, mean = 3.0 ± 0.37) to post-entry (mean = 3.4 ± 0.5) (N=3,018; mean difference: 0.41, $t=18.56$, $p<0.0001$).

Work and Rehabilitation Activity

A small number of MHICM veterans (N=612 of 4,934; 12.4%) reported full- or part-time employment in the three years before program entry. Fewer veterans (N=343, 6.9%) reported paid employment in the month before program entry (see **Figure 2-6**). Among all clients, paid work declined slightly from an average of 1.0 day at entry to 0.9 days at follow-up. Among paid veterans, paid days averaged 14.4 days at entry (N=343) and 15.5 days at follow-up (N=201). Fewer veterans

⁶Paired t-test results for client ratings of quality of life (N=2,663, mean difference: 2.62, $t=21.4$, $p<0.0001$), satisfaction with VA mental health services (multi-item: N=2,637, mean difference: 0.77, $t=16.7$, $p<0.0001$); single item: N=2,466, mean difference: 0.32, $t=13.00$, $p<0.0001$), and satisfaction with MHICM services (N=2,794, mean difference: 0.56, $t=25.66$, $p<0.0001$) were all significantly positive.

reported work as volunteers (N=205, 4.1%) or participants in “work-for-pay” (N=168, 3.4%) or formal (N=104, 2.2%) vocational rehabilitation programs at entry. At follow-up, veteran reports of paid work (N=201, 5.8%) declined, while participation in volunteer (N=161, 4.7%), “work-for-pay” (N=167, 4.9%) and formal rehabilitation (N=90, 2.8%) programs increased marginally. The relative weakness of vocational outcomes for MHICM teams may reflect: 1) absence of staff with vocational rehabilitation expertise on MHICM teams; 2) severe levels of impairment among MHICM veterans; and/or 3) low incentive for work among MHICM clients who receive extensive VA or Social Security benefits for disability. Anecdotally, some MHICM staff reported their clients were “too disabled” or “unmotivated” to work and were often refused admission by vocational rehabilitation services. New authority for VA supported employment services to target veterans with serious mental illness in compensated work therapy programs should increase access to vocational support in coming years.

Satisfaction with VA Mental Health Services

Client ratings of the overall quality of VA mental health services (VAMHSAT, 3 items), presented in **Table 2-24**, showed a statistically significant 8.2% gain from pre- (N=4,506; mean: 9.6 ± 0.6) to post-entry (mean: 10.4 ± 0.8). Clients from 82 of 84 teams (97.6%) indicated greater satisfaction with VA mental health services at follow-up. Single-item comparison of client satisfaction with MHICM and general VA mental health services using a 5-point scale (0-very dissatisfied to 5-very satisfied), summarized in **Table 2-25**, found program participants favoring MHICM (N=4,631; mean: 3.7 ± 0.3) by 18% over general services (mean: 3.2 ± 0.2). Veterans on all 84 teams (100%) showed greater satisfaction after participation in MHICM. MHICM services, which comprised the bulk of psychiatric care for most program clients, were positively associated with gains in overall satisfaction with VA mental health services, up 10.8% (mean: 3.5 ± 0.9) at follow-up.

Unit Costs

As its name suggests, Mental Health Intensive Case Management involves providing frequent services to veterans who are among the most seriously ill and most expensive to treat in the VA system. The extent of care required by this group, and the setting where services are delivered, have prompted low recommended client-to staff levels that, in turn, contribute most heavily to personnel and program expenses. Using FY 2005 program expenditures and data from previously presented tables, **Table 2-26** outlines rough program costs for various units of service. For 5,696 veterans in FY 2005, MHICM services cost about **\$7,052 per veteran**, an increase of 22% over original study data (\$5,793) unadjusted for inflation (Rosenheck, Neale, and Frisman, 1995) and 1% below FY 2004 costs (\$7,105). On the basis of FY 2005 filled positions (480.4 FTE) and personal service expenditures plus benefits (\$40.2M), the average annual cost per position was **\$80,380 per FTE** (salary plus benefits), almost 5% higher than FY 2004 (\$76,890). Adjusting total MHICM visits to reflect a full year of service for each veteran (a cumulative total of **398,152** visits for a year), the cost for MHICM services decreased slightly to **\$101 per visit** (-2%) from FY 2004. Relative to FY 2001 (when VHA Directive 2000-034 was issued), the MHICM program has grown significantly, with 36 more teams (+75%), 229 more FTE (+91%), 2,507 more clients (+79%) and 173,263 more contacts (+87%). At the same time, the average caseload per clinical FTE is a bit lower (-.83; -6%), reflecting the addition of new teams that are still developing full client caseloads and have yet to achieve typical cost-benefit levels.

Outlier Review

MHICM teams were asked to review critical monitors and minimum standards where a team value was identified as an outlier (i.e., failed to meet the minimum standard threshold or differed statistically from the median site in the undesired direction). Minimum standards were based on VHA Directive 2000-034 and critical monitor outliers were based on MHICM program guidelines and principles. For each outlier on a critical monitor or minimum standard, the team was asked to identify a reason for outlier status from among five options and to explain and address it. The Outlier Review request and review form are included in **Appendix C**.

Negative outlier values are shaded in report tables and outlined (boxed) in summary tables. Critical monitor outliers are summarized by site across monitoring domains in **Table 2-27** (Site Performance) and within domains in **Table 2-28** (Team Structure), **Table 2-29** (Client Characteristics), **Table 2-30** (Clinical Process), and **Table 2-31** (Client Outcome). Minimum standards outliers are summarized by site in **Table 2-32 A&B**. Team outlier review responses are summarized in **Table 2-33** (Outlier Review Summary) and briefly described here.

Ten MHICM teams operating in FY 2005 – Atlanta GA, Chicago IL, Chillicothe OH, Gainesville FL, Hampton VA, Iowa City IA, Knoxville IA, Portland OR, Togus ME and Topeka KS - had no outlier values – up from 4 teams in FY 2004. The 74 remaining teams in FY 2005 accounted for 205 negative outliers (2.8 outliers per team), a rate comparable to FY 2004 (186 outliers {2.8 outliers per team} among 67 teams). Eleven teams (13%) had five or more outliers, also comparable to FY 2004 (10 teams, 14%). In order of frequency, outlier review responses from 74 teams indicated: (C) Problems in program implementation for which corrective action had been taken (Sites: 37 or 44% of sites; Responses: 60 or 29% of total outliers); (D) Problems in program implementation for which corrective action was planned (Sites: 22 or 26%; Responses: 36 or 18%); (A) Legitimate team differences that did not conflict with national program goals (Sites: 38 or 45%; Responses: 67 or 33%); (B) Local policies that conflicted with national program goals (Sites: 18 or 21%; Responses: 28 or 14%); and (E) Implementation problems for which no corrective action was planned (Sites: 10 or 12%; Responses: 14 or 7%).

By domain, Team Structure outliers remained the most common (100 outliers at 60 sites, 71%), followed by outliers in Clinical Process (53 outliers, 36 sites, 43%), Clinical Outcome (39 outliers, 30 sites, 36%), and Client Characteristics (13 outliers, 13 sites, 16%). By monitor, outliers were most common for Team Size (35 teams), Physician Support (27), Caseload Size (19), Unfilled FTE (17), Face-to-Face Contact and Observed Symptoms (16), and least likely for Psychotic Diagnosis and Location of Contact (0), GAF at Entry and Quality of Life (1) and Unassigned Nurse Support (2). Results corroborate team reports of problems maintaining staff resources to provide intensive services for veterans with serious mental illness and general adherence to ACT fidelity standards.

Adherence to Minimum Standards

VHA Directive 2000-034 established procedural guidelines for MHICM teams that were operationalized in eight **minimum program standards**. FY 2005 outliers for MHICM minimum program standards (see page 16) are presented by site in Table 2-32A and B. Adherence was good or

excellent (80% or better) for six standards and fair or poor (less than 80%) for the other two. Among standards with higher adherence, all eighty-four teams (100%) reported that the majority of veterans they treated had psychiatric diagnoses including psychosis (i.e., schizophrenia, schizo-affective or bipolar disorder, other psychosis) (Mean: 89%; Range: 61% to 100%) and received most MHICM clinical services in community settings (Mean: 90%; Range: 56% to 100%). Seventy-three teams (87%) met the criterion of discharging fewer than 20 percent of their clients per year (Mean: 13%; Range: 0% to 37%). Seventy-two teams (86%) reported that a majority of their clients (Mean: 73%; Range: 23% to 100%) had 30 or more psychiatric inpatient hospital days in the year before program admission and seventy-one teams (87%) reported that at least one quarter of their clients received rehabilitation services (e.g., client skills training) (Mean: 50%; Range: 0% to 98%). Sixty-eight teams (81%) had at least weekly face-to-face contact with their clients (Mean: 1.34; Range: 0.43 to 3.00).

Among standards with a lower adherence rate, sixty-five teams (77%) maintained client to staff ratios between 7:1 and 15:1 (Mean: 12.4; Range: 5.7 to 23.0). Forty-nine teams (58%) had 4 or more clinical FTEE available to provide community-based services (Mean: 4.7; Range: 1.5 to 11.5 FTEE). Non-adherence to the staffing standard appeared to be a consequence of staff reallocation. Most teams that did not meet the staffing standard were funded initially with four or more case manager positions but lost positions over the years as staff members were detailed to other units and not replaced. In many cases, staff losses coincided with higher caseloads and lower contact frequency. Twenty-five of eighty-four MHICM teams (30%) met all eight minimum program standards in FY 2005, comparable with 18 teams (25%) in FY 2004 and 15 teams (24%) in FY 2003.

Transition to Lower Intensity Case Management Services

VHA Directive 2006-004 (Appendix A) defines a procedure for transitioning MHICM clients to lower intensity services. Teams may begin to assess client readiness for a lower level of care, after one year of MHICM services, using five criteria: “clinically stable, not abusing addictive substances, not relying on extensive inpatient or emergency services, capable of maintaining themselves in a community living situation, and independently participating in necessary treatments”. Clients who meet all criteria may be transitioned to less intensive MHICM services or to standard clinical services.

As mandated by the Directive, NEPEC began monitoring client transition to lower intensity services during FY 2000. Through FY 2002, 547 MHICM veterans were transitioned to less intensive services: 67% to lower intensity services by the MHICM team, 20% to low intensity services elsewhere, and 10% discharged without additional services. When transitioned, veterans were assessed as: clinically stable (80%); not abusing addictive substances (68%); not relying on extensive inpatient or emergency services (75%); capable of maintaining themselves in a community living situation (68%); and independently participating in necessary treatments (63%). These data indicate that up to one-third of transitioned veterans did not fully meet VHA Directive 2006-004 criteria, though the majority continued to receive low intensity services from the MHICM team. Transitioned veterans continued to receive a range of clinical services, including case management (63%), day treatment (13%), outpatient mental health therapy (47%), outpatient medication management (68%), substance abuse services (8%), residential services (24%), vocational services (10%), inpatient care (11%), or nursing home care (7%). Only 28 veterans (5%) were later restored to regular MHICM services (most re-hospitalized) because of real or imminent risk to themselves or others, impaired ability to care for self, and unwillingness or inability to participate in needed treatments. Teams reported that 14 clients (3%) may have been at

greater risk due to transition to less intensive services.

At the end of FY 2005, 359 veterans (7%) were receiving low intensity case management services from 51 MHICM teams (61%). During the year, 159 MHICM veterans (3% of 5,696) were transitioned to less intensive services: 42% to lower intensity MHICM services, 35% to low intensity services elsewhere, and 16% discharged without additional services. Six veterans were later restored to regular MHICM services due to real or imminent risk to themselves or others. When transitioned, veterans were assessed as: clinically stable (81%); not abusing addictive substances (72%); not relying on extensive inpatient or emergency services (70%); capable of maintaining themselves in a community living situation (75%); and independently participating in necessary treatments (65%). Transitioned veterans continued to receive case management (37%), day treatment (14%), outpatient mental health therapy (61%), outpatient medication management (69%), substance abuse services (10%), residential services (26%), vocational services (12%), inpatient care (12%), or nursing home care (8%). Two clients were viewed as possibly at greater risk due to transition to less intensive services.

MHICM VERA Complex Class Status

In FY 2002, MHICM veterans became eligible for Complex Class reimbursement status under VERA (Veterans Equitable Resource Allocation) if registered in a MHICM program (participated in NEPEC program monitoring) and receiving 41 or more clinic stops (visits) under DSS Identifier 552 during the Fiscal Year. For FY 2005, average Complex Care funding under VERA was \$33,043 per veteran. FY 2005 Allocation Resource Center data indicate that 3,241 (56.9%) of 5,696 MHICM veterans covered by this report were included in the MHICM complex class reimbursement category and 1,535 veterans (26.9%) were included in the Chronic Mental Illness patient class, for a total of 4,776 MHICM veterans (83.8%) receiving complex class reimbursement for serious mental illness. Also, 147 veterans qualified for MHICM complex class reimbursement at sites not covered by this report. **Appendix G** presents totals for MHICM complex class veterans for FY 2005 by facility.

MHICM Services for MHICM and Non-MHICM Veterans

MHICM visits are recorded in VA outpatient databases under DSS Identifier or Stop Code 552. Non-MHICM or general case management contacts (typically low intensity) are reported under identifier 564. FY 2005 workload data for MHICM veterans are summarized in **Appendix E** (see also Table 2-14) and for non-MHICM veterans in **Appendix F**. For the 84 teams covered by this report, **MHICM veterans** (N=5,397) received 307,479 regular MHICM (stop code 552) visits in FY 2005, an average of 57 visits per veteran (Appendix E). MHICM visits represented 99% of total client services for this group. A small minority of MHICM veterans (N=170 or 3%), at twenty-two sites, received 1,301 general case management (stop code 564) visits (about 7 visits per client). A large number of **Non-MHICM veterans** (N=2,458) were credited with MHICM visits, typically at facilities with established or developing MHICM teams. Contacts for these veterans (17,786 visits) were about half (48%) of total case management services and averaged 7 visits per veteran. Most of these visits presumably involved assessment or screening, or incorrect assignment of clinic stop code 552 (MHICM visit). Only veterans who are fully enrolled or registered in the performance monitoring system are considered MHICM participants under VHA Directive 2006-004. Non-MHICM veterans (N=2,605) also received general case management services (19,221 visits), an average of 7 visits per veteran. Many of these contacts were reported by facilities without a MHICM team.

Program Performance Trends: 1997 to 2005

This is the ninth MHICM performance monitoring report, dating back to FY 1997. Beginning with the FY 2004 report, we will summarize trends in program performance by monitoring domain, comparing the latest results (FY 2005) with those for the first report (FY 1997) and the three most recent years (FY 2002 to FY 2004). These data are presented in **Appendix H**.

Data on **team structure** show significant increases in the number of MHICM teams (+110%), clients (+182%) and staff (+217%), as well as program expenditures (+166%) since 1997. Most of this change has come since October 2000 with implementation of VHA Directive 200-034. Positions remain filled at the same level as last year (+1%). The percentage of teams with at least one team member detailed to another service has increased dramatically (+188%). Program cost per client increased (+17%, unadjusted for inflation) and the client to staff ratio held steady (+1%).

Client characteristics data indicate an increase in the number of veterans from minority racial/ethnic groups (+33%) since 1997. Reflecting VHA's shift toward outpatient services, client days in hospital have decreased (-45%) and the proportions of clients with 30 or more hospital days (-20%) and 2 or more years of lifetime hospitalization (-29%) also have declined. The vast majority of MHICM clients continue to have a psychotic diagnosis (+2%). Despite some targeting of clients with co-occurring substance use, that group has decreased somewhat (-20%) since 1997. Client participation in paid employment prior to entry is unchanged (-2%) while receipt of public support income has increased slightly (+4%).

Service delivery data provide evidence that MHICM veterans continue to be contacted weekly (+6%) if less frequently (-13%) than in 1997. FY 2005 contacts remained at the FY 2002 level. More clients receive the majority of their services in community settings (+16%) than in 1997. The rate of discharge is slightly lower (-19%), reflecting a large increase in new teams and veterans, even as more veterans (currently 8%) are transitioned to less intensive services by the team. Veteran ratings of their therapeutic alliance with MHICM staff have increased (+29%) since 1997, and team fidelity to assertive community treatment principles has remained steady (4.0, 0% change).

Client outcome data show sizeable improvements in percentage reduction for both observed (86%) and reported (+133%) symptoms at follow-up, since 1997. Quality of life ratings have improved (+25%) and satisfaction with MHICM services has remained high (0% change). Although client inpatient days prior to program entry continue to decline (-42% overall), the percentage reduction in client hospital days at follow-up has increased (+13%).

Consistent with VHA's commitment to expand access to community-based services, the MHICM program has grown since 1997. MHICM has benefited from network and facility support and a national initiative to implement VHA Directive 2000-034 (now 2006-004). Review of outliers and team reports continue to underscore the importance of attention to team and caseload size and staff training. Performance monitoring data show that MHICM teams continue to target veterans who need intensive support, providing them with quality services in community settings. After eight years of MHICM performance monitoring, client outcomes are strong and satisfaction remains high.

Summary and Conclusions:

Development of Mental Health Intensive Case Management services in VA has followed a model sequence of problem identification, program development, evaluation, and dissemination (Rosenheck, 2001). Modeled on evidence-based, “best practice” programs in widespread use elsewhere in the nation (Rosenheck and Neale, 2001; Phillips et al., 2001), the MHICM program is a well-defined intervention that meets local needs within its operational parameters. A rigorous study demonstrated the program’s cost-effectiveness and long-term benefits in VA settings, as well as the need for training and monitoring to assure proper implementation. Both VA and non-VA studies show program benefits are not likely to be attained unless team operation is carefully monitored (Mueser et al., 1998). With support from the Under Secretary for Health, the Office of Mental Health Services and the SMI Committee through the Strategic Mental Health Plan, VHA Directive 2006-004 and national performance measures, MHICM has been successfully implemented at more than 90 VA healthcare systems across all networks. Site-by-site performance monitoring data show the program continues to provide effective and efficient services to deserving veterans in great need.

References

- American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders, IV, Washington DC: American Psychiatric Association.
- Bachrach LL. (1980). Overview: Model programs for chronic mental patients. *American Journal of Psychiatry*, 137: 1023-1031.
- Derogatis LR, Spencer N. (1982). The brief symptom index; Administration, scoring and procedure manual, Baltimore MD: Johns Hopkins.
- Donabedian A. (1980). Explorations in Quality Assessment and Monitoring: The Definition of Quality and Approaches to its Assessment, Vol. 1. Ann Arbor, MI: Health Administration Press.
- Endicott J, Spitzer RL, Fleiss JL, Cohen J. (1976). The global assessment scale. *Archives of General Psychiatry*, 33: 766-771.
- Fischer E, Cuffel BJ, Owen RR, Burns BJ, Hargreaves W, Karson C, Lehman A, Shern D, Smith GR, Sullivan G. (1996). Schizophrenia Outcomes Module. Little Rock, Arkansas: University of Arkansas for Medical Sciences.
- Greenberg, G, Rosenheck RA. (2006). Department of Veterans Affairs National Mental Health Program Performance Monitoring System: Fiscal Year 2005 Report. West Haven, CT: VA Northeast Program Evaluation Center Report.
- Harris M, Bergman HC. (1993). Case management for mentally ill patients: Theory and practice. Langhorne, Pennsylvania: Harwood Academic.
- Horvath AO, Greenberg L. (1989). Development and validation of the working alliance inventory. *Journal of Counseling Psychology*, 36, 223-233.
- Kanter J. (1989). Clinical case management: Definition, principles, components. *Hospital and Community Psychiatry*, 40, 361-368.
- Lehman AF. (1988). A quality of life interview for the chronically mentally ill. *Evaluation and Program Planning*, 11:51-62.
- McGrew JH, Bond GR, Dietzen LL et al. (1994). Measuring the fidelity of implementation of a mental health program model. *Journal of Consulting and Clinical Psychology*, 62: 670-678.
- Mueser KT, Bond GR, Drake RE et al: Models of community care for severe mental illness: A review of research on case management. *Schizophrenia Bulletin* 24(1):37-74, 1998.
- Neale MS, Rosenheck RA. (1995). Therapeutic alliance and outcome in a VA intensive case management program. *Psychiatric Services*, 46: 719-721.

Neale MS, Rosenheck RA, Castrodonatti J, Martin A, Morrissey J, Anderson J. (2005). Mental health intensive case management (MHICM) in the department of veterans affairs: The eighth national performance monitoring report–FY 2004. West Haven, CT: VA Northeast Program Evaluation Center Report (www.nepec.med.va.gov).

Overall JE, Gorham DR. (1962). Brief psychiatric rating scale. *Psychological Reports*, 10: 799-812.

Phillips SD, Burns BJ, Edgar ER, Mueser KT, Linkins KW, Rosenheck RA, Drake RE, McDonell Herr EC. (2001). Moving assertive community treatment into standard practice. *Psychiatric Services*, 52: 771-9.

Rosenheck RA. (2001). Organizational process: A missing link between research and practice. *Psychiatric Services*, 52: 1627-1632.

Rosenheck RA, Neale MS. (1998a). Cost-effectiveness of intensive psychiatric community care for high users of inpatient services, *Archives of General Psychiatry*, 55: 459-466.

Rosenheck RA, Neale MS. (1998b). Inter-site variation in impact of intensive psychiatric community care on hospital use. *American Journal of Orthopsychiatry*, 68: 191-200.

Rosenheck RA, Neale MS. (2001). Development, implementation, and monitoring of intensive psychiatric community care in the department of veterans affairs. In B. Dickey and L. Sederer (Eds.), *Achieving quality in psychiatric and substance abuse practice: Concepts and case reports*. Washington, DC: American Psychiatric Publishing.

Rosenheck RA, Neale MS, Baldino R, Cavallaro L. (1997). Intensive psychiatric community care (IPCC): Dissemination of a new approach to care for veterans with serious mental illness in the department of veterans affairs. West Haven, CT: VA Northeast Program Evaluation Center Report.

Rosenheck, RA, Neale, MS, Frisman, LK. (1995). Issues in estimating the cost of innovative mental health programs. *Psychiatric Quarterly*, 66, 9-31.

Rosenheck R, Neale M, Leaf P, Milstein R, Frisman L. (1995). Multisite experimental cost study of intensive psychiatric community care. *Schizophrenia Bulletin*, 21: 129-140.

Teague GB, Bond GR, Drake RE. (1998). Program fidelity in assertive community treatment: Development and use of a measure. *American Journal of Orthopsychiatry*, 68: 216-232.

Teague GB, Drake RE, Ackerson TH. (1995). Evaluating use of continuous treatment teams for persons with mental illness and substance abuse. *Psychiatric Services*, 46: 689-695.

Under Secretary for Health, US Department of Veterans Affairs. (2006). VHA Directive 2006-004 (January 30, 2006). VHA Mental Health Intensive Case Management. Washington DC: US Department of Veterans Affairs, Veterans Health Administration.

Table 2-1. VA MHICM Program Monitors

Monitoring Domain	Program Monitor	Unit	Report Table[^]	Program Objective	Critical Monitor
I. Structure	1. Total FTE allocated to date	#	2-3	1	
	2. Actual FTEE filled (September 30, 2003)	#	2-5	1	
	3. % FTE utilized	%	2-5	1	
	4. Total funds (PS, AO, AS, TOT) allocated	\$	2-3	1	
	5. Actual funds expended (FY 2003)	\$	2-4	1	
	6. Medical support (.2MD, 1.0RN)	Y/N	2-6	1	*
	7. Clinical FTEE	#	2-6	1	+
	8. FTE unfilled or lagged GTE 6 months	Y/N	2-5	1	*
	9. FTE assigned to non-MHICM activities	Y/N	2-5	1	
	10. # Total veterans enrolled (9/30/03)	#	2-6	1	
	11. Caseload size (vet/staff: 7-15/Clinical FTE)	ratio	2-6	1	*+
II. Client	12. % Caseload entered as inpatient	%	2-8	1	
	13. % Caseload w/CLOS GTE 30 (yr of entry)	%	2-8/10	1	*+
	14. % Caseload w/psychotic diagnosis at entry	%	2-8/10	1	*+
	15. % Age at entry (by category)	%	2-7	na	
	16. % Minority status	%	2-7	na	
	17. % Dual diagnosis	%	2-8	na	
	18. Lifetime psych hospital use (% GT 2 yrs)	%	2-10	3	
	19. % Receiving public support (any source)	%	2-8/9	1	
	20. % Receiving VA compensation or pension	%	2-8/9	1	
	21. % Employed (FT/PT) in past 3 years	%	2-7	1	
	22. Global functioning at entry (% GAF GTE 50)	%	2-11	4	*
	23. IADL skills (% domains rarely/never)	%	2-11	4	
	24. Severity of illness (Mean BPRS score)	#	2-11	2	
III. Process	25. # New veterans added	#	2-12	1	
	26. % Clients terminated (Continuity)	%	2-12	1	*+
	27. % Clients seen weekly + (Frequency)	%	2-13	1	
	28. % Clients seen 61+mins/wk seen (Intensity)	%	2-13	1	*
	29. % Clients seen 61%+ community (Location)	%	2-13	1	*+
	30. # Face-to-face contacts/wk (Adj mean/wk)	#	2-14	1	*+~
	31. % Clients seen for rehabilitation	%	2-15	4	+
	32. % Clients seen for substance abuse	%	2-15	2	
	33. % Change therapeutic alliance	%	2-16	5	
	34. % Fidelity to ACT Model	%	2-17	1	
IV. Outcome	35. # Mean VA hospital days post-entry (6 mos)	#	2-18	3	*
	36. % Change in VA hospital days (6 mos)	%	2-18	3	
	37. \$ Estimated change in VA healthcare cost	\$	2-18	6	
	38. % Client symptoms improved (BPRS)	%	2-19	2	*
	39. % Client symptoms improved (BSI)	%	2-20	2	*
	40. % Client functioning improved (GAF)	%	2-21	4	*
	41. % Client functioning improved (IADL)	%	2-22	4	*
	42. % Client quality of life improved (QOLI)	%	2-23	4	*
	43. % Client satisfaction: VA mental health care	%	2-24	5	
	44. % Client satisfaction: MHICM vs. VA MH care	%	2-25	5	*
V. Cost	45. \$ Cost per veteran	\$	2-26	6	
	46. \$ Cost per FTEE	\$	2-26	6	
	47. \$ Cost per visit	\$	2-26	6	

*Critical MHICM monitor; + Minimum program standard; ~ Minimum standard replaces critical monitor standard.

[^]Chapter 2 summarizes table data; Appendix D provides a complete set of column definitions for all tables.

TABLE 2-2. MHICM PROGRAMS THROUGH FY 2005

VISN	SITE NAME ~	SITE CODE	SITE TYPE	MHICM START-UP YEAR
1	BEDFORD	518	NP	1995
1	BROCKTON	523A5	NP	1987
1	TOGUS	402	GM&S	1995
1	WEST HAVEN	689	GM&S	1987
2	ALBANY	528A8	GM&S	1987
2	BUFFALO	528	GM&S	1987
2	CANANDAIGUA	528A5	NP	1987
2	SYRACUSE	528A7	GM&S	1987
3	BROOKLYN	630A4	GM&S	1995
3	HUDSON VALLEY	620	NP	1987
3	NEW JERSEY	561	GM&S	1995
3	NORTHPORT	632	NP	2001
4	COATESVILLE	542	NP	1995
4	LEBANON	595	NP	2005
4	PHILADELPHIA	642	GM&S	2004
4	PITTSBURGH	646A5	NP	1994
5	BALTIMORE	512	GM&S	2002
5	MARTINSBURG	613	GM&S	2004
5	PERRY POINT	512A5	NP	1994
5	WASHINGTON, DC	688	GM&S	2002
6	FAYETTEVILLE	565	GM&S	2002
6	HAMPTON	590	GM&S	2002
6	SALEM	658	NP	2002
6	SALISBURY	659	NP	1994
7	ATLANTA	508	GM&S	1995
7	AUGUSTA	509	NP	1995
7	BIRMINGHAM	521	GM&S	2004
7	CHARLESTON	534	GM&S	2005
7	COLUMBIA	544	GM&S	2004
7	TUSCALOOSA	679	NP	2001
7	TUSKEGEE	619A4	NP	1995
8	GAINESVILLE	573	GM&S	1995
8	MIAMI	546	GM&S	1994
8	TAMPA	673	GM&S	1995
8	WEST PALM BEACH	548	GM&S	2005
10	AKRON	541GG	GM&S	2005
10	CHILLICOTHE	538	NP	1995
10	CINCINNATI	539	GM&S	1999
10	CLEVELAND	541	GM&S	1994
10	COLUMBUS	757	GM&S	1999
10	DAYTON	552	GM&S	1999
10	MANSFIELD	541GD	GM&S	2005
10	YOUNGSTOWN	541B2	GM&S	2001
11	ANN ARBOR	506	GM&S	1995
11	BATTLE CREEK	515	NP	1995
11	DANVILLE	550	NP	2004
11	DETROIT	553	GM&S	1998
11	NORTHERN INDIANA	610	NP	2001
12	CHICAGO-WEST SIDE	537	GM&S	1992
12	MADISON	607	GM&S	1995
12	MILWAUKEE	695	GM&S	2001
12	NORTH CHICAGO	556	NP	1995
12	TOMAH	676	NP	2002
15	ST. LOUIS	657	GM&S	2003
15	TOPEKA	677	NP	2002
16	GULF COAST	520	GM&S	2001

TABLE 2-2. MHICM PROGRAMS THROUGH FY 2005

VISN	SITE NAME ~	SITE CODE	SITE TYPE	MHICM START-UP YEAR
16	HOUSTON	580	GM&S	2001
16	LITTLE ROCK	598	GM&S	2000
16	NEW ORLEANS	629	GM&S	2001
17	DALLAS	549	GM&S	1995
17	SAN ANTONIO	671	GM&S	2005
17	TEMPLE (WACO)	685	NP	1995
18	ALBUQUERQUE	501	GM&S	2003
18	PHOENIX	644	GM&S	2002
19	DENVER	554	GM&S	1995
19	FORT HARRISON	436	GM&S	2002
19	GRAND JUNCTION	575	GM&S	2000
19	SALT LAKE CITY	660	GM&S	2000
19	SHERIDAN	666	NP	2001
19	SOUTHERN COLORADO	567	NP	2000
20	AMERICAN LAKE	663A4	NP	1994
20	BOISE	531	GM&S	1995
20	PORTLAND	648	GM&S	1992
20	SEATTLE	663	GM&S	1995
21	PALO ALTO	640	GM&S	2002
21	SAN FRANCISCO	662	GM&S	1995
22	GREATER LOS ANGELES	691	GM&S	1994
22	LONG BEACH	600	GM&S	2005
22	SAN DIEGO	664	GM&S	2003
23	IOWA CITY	636A8	GM&S	2003
23	KNOXVILLE	636A7	NP	1999
23	MINNEAPOLIS	618	GM&S	1995
23	OMAHA	636	GM&S	2003
23	ST.CLOUD	656	NP	2001

~MHICM teams (N=8) with insufficient data to be included in this Report:
Durham, Louisville, Memphis, Tennessee Valley, Indianapolis, Hines, Tucson,
and Loma Linda. No signed reports from Ann Arbor and Palo Alto.

TABLE 2-3. ALLOCATED STAFF AND FUNDS (ORIGINAL DOLLARS)

VISN	SITE NAME	ALLOCATED FTE	PERSONAL SERVICE	ALL OTHER	ADMIN SUPPORT	TOTAL PROGRAM \$
1	BEDFORD	6.20	\$582,020	\$15,000	\$30,000	\$627,020
1	BROCKTON	10.50	\$392,315	\$52,006	\$0	\$444,321
1	TOGUS	3.50	\$200,000	\$15,000	\$20,000	\$235,000
1	WEST HAVEN	11.00	\$404,862	\$27,000	\$14,686	\$446,548
2	ALBANY	10.00	\$341,000	\$1,985	\$0	\$342,985
2	BUFFALO	8.50	\$273,000	\$12,000	\$0	\$285,000
2	CANANDAIGUA	11.60	\$343,052	\$42,844	\$0	\$385,896
2	SYRACUSE	4.30	\$174,671	\$5,200	\$11,500	\$191,371
3	BROOKLYN	6.20	\$300,000	\$15,000	\$30,000	\$345,000
3	HUDSON VALLEY	4.50	\$225,144	\$85,456	\$0	\$310,600
3	NEW JERSEY	7.70	\$562,527	\$23,977	\$26,000	\$612,504
3	NORTHPORT	7.03	\$601,865	\$29,553	\$0	\$631,418
4	COATESVILLE	6.20	\$300,000	\$15,000	\$30,000	\$345,000
4	LEBANON	5.00	\$380,025	\$22,259	\$0	\$402,284
4	PHILADELPHIA	4.70	\$406,611	\$8,400	\$0	\$415,011
4	PITTSBURGH	6.50	\$300,000	\$25,000	\$45,000	\$370,000
5	BALTIMORE	4.70	\$329,499	\$14,883	\$0	\$344,382
5	MARTINSBURG	4.70	\$329,499	\$14,883	\$0	\$344,382
5	PERRY POINT	6.50	\$315,326	\$25,000	\$45,000	\$385,326
5	WASHINGTON, DC	3.00	\$295,061	\$15,034	\$0	\$310,095
6	FAYETTEVILLE	3.00	\$295,061	\$15,034	\$0	\$310,095
6	HAMPTON	4.64	\$319,021	\$22,393	\$0	\$341,414
6	SALEM	4.20	\$300,020	\$0	\$0	\$300,020
6	SALISBURY	6.50	\$300,000	\$50,000	\$45,000	\$395,000
7	ATLANTA	5.20	\$260,000	\$15,000	\$26,000	\$301,000
7	AUGUSTA	6.20	\$288,052	\$15,000	\$28,805	\$331,857
7	BIRMINGHAM	4.50	\$219,081	\$8,353	\$0	\$227,434
7	CHARLESTON	4.20	\$406,728	\$11,505	\$0	\$418,233
7	COLUMBIA	4.00	\$317,839	\$0	\$0	\$317,839
7	TUSCALOOSA	8.10	\$541,543	\$18,798	\$0	\$560,341
7	TUSKEGEE	3.50	\$200,000	\$15,000	\$20,000	\$235,000
8	GAINESVILLE	5.20	\$282,500	\$15,000	\$26,000	\$323,500
8	MIAMI	7.30	\$364,456	\$23,620	\$25,000	\$413,076
8	TAMPA	6.00	\$310,010	\$16,817	\$0	\$326,827
8	WEST PALM BEACH	5.70	\$433,961	\$10,286	\$0	\$444,247
10	AKRON	5.50	\$519,908	\$12,314	\$0	\$532,222
10	CHILLICOTHE	6.20	\$300,000	\$15,000	\$30,000	\$345,000
10	CINCINNATI	4.00	\$130,000	\$9,000	\$0	\$139,000
10	CLEVELAND	6.50	\$300,000	\$25,000	\$45,000	\$370,000
10	COLUMBUS	4.00	\$130,000	\$9,000	\$0	\$139,000
10	DAYTON	4.00	\$130,000	\$9,000	\$0	\$139,000
10	MANSFIELD	5.60	\$408,984	\$10,560	\$0	\$419,544
10	YOUNGSTOWN	4.33	\$309,266	\$11,616	\$0	\$320,882
11	ANN ARBOR	5.20	\$240,000	\$15,000	\$24,000	\$279,000
11	BATTLE CREEK	6.20	\$300,000	\$15,000	\$30,000	\$345,000
11	DANVILLE	4.00	\$262,201	\$18,342	\$0	\$280,543
11	DETROIT	9.30	\$325,000	\$75,000	\$0	\$400,000
11	NORTHERN INDIANA	6.20	\$372,474	\$11,436	\$0	\$383,910
12	CHICAGO-WEST SIDE	7.30	\$267,600	\$24,400	\$0	\$292,000
12	MADISON	3.50	\$228,000	\$15,000	\$20,000	\$263,000
12	MILWAUKEE	4.95	\$343,727	\$25,246	\$0	\$368,973
12	NORTH CHICAGO	6.20	\$300,000	\$15,000	\$30,000	\$345,000
12	TOMAH	3.88	\$259,438	\$13,351	\$0	\$272,789
15	ST. LOUIS	5.00	\$290,123	\$17,701	\$0	\$307,824
15	TOPEKA	9.50	\$628,521	\$0	\$0	\$628,521
16	GULF COAST	4.20	\$345,606	\$13,308	\$0	\$358,914
16	HOUSTON	6.00	\$457,160	\$37,896	\$0	\$495,056

TABLE 2-3. ALLOCATED STAFF AND FUNDS (ORIGINAL DOLLARS)

VISN	SITE NAME	ALLOCATED FTE	PERSONAL SERVICE	ALL OTHER	ADMIN SUPPORT	TOTAL PROGRAM \$
16	LITTLE ROCK	4.00	\$305,889	\$62,152	\$0	\$368,041
16	NEW ORLEANS	4.84	\$397,012	\$8,585	\$0	\$405,597
17	DALLAS	6.50	\$303,107	\$15,000	\$28,000	\$346,107
17	SAN ANTONIO	3.50	\$348,013	\$7,000	\$0	\$355,013
17	TEMPLE (WACO)	4.00	\$163,000	\$15,000	\$16,300	\$194,300
18	ALBUQUERQUE	5.90	\$251,480	\$10,820	\$0	\$262,300
18	PHOENIX	8.00	\$416,084	\$16,179	\$0	\$432,263
19	DENVER	6.20	\$300,000	\$15,000	\$30,000	\$345,000
19	FORT HARRISON	3.15	\$253,661	\$3,810	\$0	\$257,471
19	GRAND JUNCTION	3.15	\$253,661	\$3,810	\$0	\$257,471
19	SALT LAKE CITY	5.75	\$316,304	\$6,445	\$0	\$322,749
19	SHERIDAN	1.50	\$118,187	\$14,345	\$0	\$132,532
19	SOUTHERN COLORADO	7.60	\$256,396	\$152,121	\$0	\$408,517
20	AMERICAN LAKE	6.50	\$280,000	\$25,000	\$45,000	\$350,000
20	BOISE	3.60	\$236,000	\$8,100	\$23,600	\$267,700
20	PORTLAND	7.00	\$268,000	\$19,500	\$0	\$287,500
20	SEATTLE	5.20	\$260,000	\$15,000	\$26,000	\$301,000
21	PALO ALTO	3.80	\$303,085	\$7,740	\$0	\$310,825
21	SAN FRANCISCO	6.50	\$300,000	\$15,000	\$30,000	\$345,000
22	GREATER LOS ANGELES	6.50	\$300,000	\$25,000	\$45,000	\$370,000
22	LONG BEACH	4.25	\$347,253	\$11,550	\$0	\$358,803
22	SAN DIEGO	6.20	\$436,468	\$17,956	\$0	\$454,424
23	IOWA CITY	4.50	\$276,281	\$33,736	\$0	\$310,017
23	KNOXVILLE	7.85	\$436,195	\$14,786	\$0	\$450,981
23	MINNEAPOLIS	5.20	\$260,000	\$15,000	\$26,000	\$301,000
23	OMAHA	5.20	\$325,156	\$13,522	\$0	\$338,678
23	ST.CLOUD	3.70	\$290,302	\$18,530	\$0	\$308,832
ALL SITES		472.22	\$26,744,291	\$1,671,143	\$871,891	\$29,287,325
SITE AVERAGE		5.62	\$318,384	\$19,895	\$10,380	\$348,659
SITE STD. DEV		1.90	\$99,708	\$20,415	\$14,986	\$101,001

Source: MHSBG Resource tables and initial site-generated Annual Reports.
 ~MHICM teams (N=8) with insufficient data to be included in this Report: Durham,
 Louisville, Memphis, Tennessee Valley, Indianapolis, Hines, Tucson, and Loma Linda. No
 signed reports from Ann Arbor and Palo Alto.

TABLE 2-4. FY 2005 PROGRAM EXPENDITURES

VISN	SITE NAME	FY 2005 FILLED FTE	FY 2005 P/S EXPEND.	FY 2005 AO EXPEND.	FY 2005 TOTAL EXPEND.
1	BEDFORD	10.88	988442	26840	1015282
1	BROCKTON	4.85	454404	0	454404
1	TOGUS	4.6	346345	13375.4	359720
1	WEST HAVEN	5.83	538941	23418.03	562359
2	ALBANY	5.35	365049.2	300	365349
2	BUFFALO	7.6	445912	11824.32	457736
2	CANANDAIGUA	9.55	659676.1	30538	690214
2	SYRACUSE	3.75	328734	0	328734
3	BROOKLYN	4.4	418611.4	0	418611
3	HUDSON VALLEY	8.5	912474	2258	914732
3	NEW JERSEY	7.9	778239	30375	808614
3	NORTHPORT	6.1	603265.1	36466.68	639732
4	COATESVILLE	6	451673.7	4265.09	455939
4	LEBANON	5	380025	22259	402284
4	PHILADELPHIA	3.7	406611	8400	415011
4	PITTSBURGH	9.1	889806	1779.83	891586
5	BALTIMORE	3.7	345145.6	8772.84	353918
5	MARTINSBURG	4	249083	0	249083
5	PERRY POINT	5.6	443769.5	13961.59	457731
5	WASHINGTON, DC	6	376340	3650	379990
6	FAYETTEVILLE	4	320609	15785	336394
6	HAMPTON	5.3	390720	20730	411450
6	SALEM	2.5	262451.1	0	262451
6	SALISBURY	4.7	411632	20000	431632
7	ATLANTA	9.2	753702	18776	772478
7	AUGUSTA	6.5	371518	1500	373018
7	BIRMINGHAM	4.02	241803	9764	251567
7	CHARLESTON	4.2	406728	11504.52	418233
7	COLUMBIA	4	327350.2	236	327586
7	TUSCALOOSA	6.6	485391	22576	507967
7	TUSKEGEE	5	301005.6	26544.23	327550
8	GAINESVILLE	6.7	507988.7	57076.39	565065
8	MIAMI	5.25	413789	20042.23	433831
8	TAMPA	8	388415	13298	401713
8	WEST PALM BEACH	4.7	433960.6	10286.28	444247
10	AKRON	4.5	519908	12314	532222
10	CHILLICOTHE	9.1	710030.3	19211.12	729241
10	CINCINNATI	9.3	719164	95749	814913
10	CLEVELAND	14	1108876	9566	1118442
10	COLUMBUS	3.66	198558.5	13540.06	212099
10	DAYTON	9.7	703462.6	20956.86	724420
10	MANSFIELD	5.1	408984	10560	419544
10	YOUNGSTOWN	5.25	385985	11664	397649
11	ANN ARBOR	5.2	355355	42572	397927
11	BATTLE CREEK	6.2	419639	19498	439137
11	DANVILLE	4	262201	18341.6	280543
11	DETROIT	6.93	538250	6500	544750
11	NORTHERN INDIANA	6.9	552079.8	77548.98	629629
12	CHICAGO-WEST SIDE	6.25	449212.9	0	449213
12	MADISON	4.63	433258	43640	476898
12	MILWAUKEE	4.45	418903.5	19946.24	438850
12	NORTH CHICAGO	8.33	792021	19925	811946
12	TOMAH	2.81	229451	14061	243512
15	ST. LOUIS	5	360508	25303.05	385811
15	TOPEKA	8.3	517265	0	517265
16	GULF COAST	5.7	324605	5709	330314

TABLE 2-4. FY 2005 PROGRAM EXPENDITURES

VISN	SITE NAME	FY 2005 FILLED FTE	FY 2005 P/S EXPEND.	FY 2005 AO EXPEND.	FY 2005 TOTAL EXPEND.
16	HOUSTON	4.1	469783	18165.29	487948
16	LITTLE ROCK	5	423034	9590	432624
16	NEW ORLEANS	4.88	397012	8585	405597
17	DALLAS	8	644067	11434.67	655502
17	SAN ANTONIO	3.5	348013	7000	355013
17	TEMPLE (WACO)	5	401321	19174	420495
18	ALBUQUERQUE	6.7	491388	28560	519948
18	PHOENIX	5.5	446705	23217	469922
19	DENVER	5.5	489327	1260	490587
19	FORT HARRISON	1	292912.2	0	292912
19	GRAND JUNCTION	4	242763	4200	246963
19	SALT LAKE CITY	5.5	463278	12241	475519
19	SHERIDAN	1.5	138378	93023	231401
19	SOUTHERN COLORADO	6.25	493716	93076	586792
20	AMERICAN LAKE	4.65	347538.5	785	348324
20	BOISE	3.55	297110.1	8193.47	305304
20	PORTLAND	7.5	660898	22479	683377
20	SEATTLE	4.1	347538.5	785	348324
21	PALO ALTO	6.9	450056	8400	458456
21	SAN FRANCISCO	3.7	450773	24876	475649
22	GREATER LOS ANGELES	7	626697.5	24419.88	651117
22	LONG BEACH	4.25	347253	11550	358803
22	SAN DIEGO	5.7	465380.1	2000	467380
23	IOWA CITY	5.3	368211	53880	422091
23	KNOXVILLE	8.5	591415	58936	650351
23	MINNEAPOLIS	6.2	468255.2	0	468255
23	OMAHA	5.11	372486.7	16374.51	388861
23	ST.CLOUD	3.1	270070	18857	288927
ALL SITES		480.38	\$38,612,707	\$1,554,270	\$40,166,978
SITE AVERAGE		5.72	\$459,675	\$18,503	\$478,178
SITE STD. DEV		2.11	\$176,238	\$20,527	\$179,964

* Expenditures include space rental.

~MHICM teams (N=8) with insufficient data to be included in this Report: Durham, Louisville, Memphis, Tennessee Valley, Indianapolis, Hines, Tucson, and Loma Linda. No signed reports from Ann Arbor and Palo Alto. -FY04 data utilized in absence of signed annual report.

Source: MHICM Local Progress Reports FY2005

TABLE 2-5. UTILIZATION OF STAFF RESOURCES

VISN	SITE NAME	ALLOCATED FTE	FY FILLED FTE	% FTE UTILIZED	SEPT. CLINICAL FTE^	FTE UNFILLED GTE 6 MO.	FTE ASSIGNED TO NON-MHICM
1	BEDFORD	13.88	10.88	78.4%	9.50	N	N
1	BROCKTON	6.35	4.85	76.4%	4.10	N	Y
1	TOGUS	4.60	4.60	100.0%	4.00	N	N
1	WEST HAVEN	9.53	5.83	61.2%	4.95	Y	Y
2	ALBANY	5.35	5.35	100.0%	3.75	N	Y
2	BUFFALO	7.60	7.60	100.0%	6.00	N	N
2	CANANDAIGUA	9.55	9.55	100.0%	9.30	N	N
2	SYRACUSE	3.75	3.75	100.0%	3.00	Y	Y
3	BROOKLYN	6.40	4.40	68.8%	3.90	N	N
3	HUDSON VALLEY	8.50	8.50	100.0%	7.50	N	N
3	NEW JERSEY	8.90	7.90	88.8%	7.50	N	Y
3	NORTHPORT	6.10	6.10	100.0%	5.80	Y	N
4	COATESVILLE	6.40	6.00	93.8%	5.60	Y	N
4	LEBANON	5.00	5.00	100.0%	3.50	N	N
4	PHILADELPHIA	4.70	3.70	78.7%	2.75	N	Y
4	PITTSBURGH	9.10	9.10	100.0%	7.50	N	Y
5	BALTIMORE	5.20	3.70	71.2%	3.50	Y	N
5	MARTINSBURG	4.00	4.00	100.0%	3.50	N	N
5	PERRY POINT	7.60	5.60	73.7%	4.25	Y	N
5	WASHINGTON, DC	6.00	6.00	100.0%	4.00	N	N
6	FAYETTEVILLE	4.20	4.00	95.2%	3.50	Y	Y
6	HAMPTON	5.30	5.30	100.0%	4.50	N	N
6	SALEM	4.50	2.50	55.6%	1.50	N	Y
6	SALISBURY	4.70	4.70	100.0%	4.00	N	N
7	ATLANTA	10.20	9.20	90.2%	8.50	N	Y
7	AUGUSTA	6.50	6.50	100.0%	5.50	N	N
7	BIRMINGHAM	4.02	4.02	100.0%	3.50	N	N
7	CHARLESTON	4.20	4.20	100.0%	3.50	N	N
7	COLUMBIA	4.00	4.00	100.0%	3.50	N	Y
7	TUSCALOOSA	8.60	6.60	76.7%	4.50	Y	Y
7	TUSKEGEE	6.00	5.00	83.3%	4.50	Y	N
8	GAINESVILLE	6.70	6.70	100.0%	4.00	N	N
8	MIAMI	6.25	5.25	84.0%	3.50	N	N
8	TAMPA	8.00	8.00	100.0%	6.50	N	N
8	WEST PALM BEACH	5.70	4.70	82.5%	3.00	N	Y
10	AKRON	5.50	4.50	81.8%	3.50	Y	N
10	CHILLICOTHE	9.10	9.10	100.0%	9.00	N	Y
10	CINCINNATI	10.30	9.30	90.3%	8.50	N	N
10	CLEVELAND	15.00	14.00	93.3%	11.50	N	N
10	COLUMBUS	3.66	3.66	100.0%	3.33	N	N
10	DAYTON	11.70	9.70	82.9%	9.00	N	Y
10	MANSFIELD	5.60	5.10	91.1%	4.50	Y	N
10	YOUNGSTOWN	5.25	5.25	100.0%	4.50	N	N
11	ANN ARBOR	5.20	5.20	100.0%	3.50	N	N
11	BATTLE CREEK	6.20	6.20	100.0%	5.00	N	N
11	DANVILLE	4.00	4.00	100.0%	3.50	N	N
11	DETROIT	7.93	6.93	87.4%	6.00	N	N
11	NORTHERN INDIANA	8.90	6.90	77.5%	5.00	N	N
12	CHICAGO-WEST SIDE	6.25	6.25	100.0%	5.50	N	N
12	MADISON	4.63	4.63	100.1%	3.30	N	N
12	MILWAUKEE	4.95	4.45	89.9%	3.00	N	N
12	NORTH CHICAGO	13.33	8.33	62.5%	6.50	Y	Y
12	TOMAH	3.81	2.81	73.8%	2.25	N	N
15	ST. LOUIS	5.00	5.00	100.0%	3.50	N	N
15	TOPEKA	9.30	8.30	89.2%	6.50	N	N

TABLE 2-5. UTILIZATION OF STAFF RESOURCES

VISN	SITE NAME	ALLOCATED FTE	FY FILLED FTE	% FTE UTILIZED	SEPT. CLINICAL FTE^	FTE UNFILLED GTE 6 MO.	FTE ASSIGNED TO NON-MHICM
16	GULF COAST	5.70	5.70	100.0%	4.50	N	N
16	HOUSTON	5.10	4.10	80.4%	3.50	Y	N
16	LITTLE ROCK	5.00	5.00	100.0%	4.00	N	N
16	NEW ORLEANS	4.88	4.88	100.1%	3.50	N	N
17	DALLAS	8.00	8.00	100.0%	6.50	N	N
17	SAN ANTONIO	3.50	3.50	100.0%	3.00	N	N
17	TEMPLE (WACO)	5.00	5.00	100.0%	4.50	N	N
18	ALBUQUERQUE	7.70	6.70	87.0%	4.20	N	N
18	PHOENIX	5.50	5.50	100.0%	5.50	N	N
19	DENVER	6.50	5.50	84.6%	4.50	N	N
19	FORT HARRISON	1.00	1.00	100.0%	1.00	N	Y
19	GRAND JUNCTION	4.00	4.00	100.0%	3.50	N	N
19	SALT LAKE CITY	5.50	5.50	100.0%	5.25	N	Y
19	SHERIDAN	1.50	1.50	100.0%	1.20	N	N
19	SOUTHERN COLORADO	6.25	6.25	100.0%	5.50	N	N
20	AMERICAN LAKE	4.90	4.65	94.9%	4.00	N	N
20	BOISE	3.55	3.55	100.0%	3.00	N	N
20	PORTLAND	7.50	7.50	100.0%	6.30	N	N
20	SEATTLE	5.10	4.10	80.4%	3.45	Y	N
21	PALO ALTO	6.90	6.90	100.0%	3.00	Y	N
21	SAN FRANCISCO	3.70	3.70	100.0%	3.00	N	N
22	GREATER LOS ANGELE	7.00	7.00	100.0%	5.50	N	N
22	LONG BEACH	4.25	4.25	100.0%	3.50	N	N
22	SAN DIEGO	6.20	5.70	91.9%	4.00	Y	Y
23	IOWA CITY	5.30	5.30	100.0%	4.00	N	N
23	KNOXVILLE	8.50	8.50	100.0%	7.00	N	N
23	MINNEAPOLIS	6.20	6.20	100.0%	4.50	N	N
23	OMAHA	5.11	5.11	100.0%	3.50	N	N
23	ST.CLOUD	3.60	3.10	86.1%	2.50	Y	N
ALL SITES		525.93	480.38	91.3%	392.68		
SITE AVERAGE		6.26	5.72	92.7%	4.67	20.2%	22.6%
SITE STD. DEV		2.47	2.11	10.8%	1.94		

* Extended staff vacancy in FY 2005.

^ Outlined values deviate from minimum staffing standard (4.0 Clinical FTE) or expected staffing.

~MHICM teams (N=8) with insufficient data to be included in this Report: Durham, Louisville, Memphis, Tennessee Valley, Indianapolis, Hines, Tucson, and Loma Linda. No signed reports from Ann Arbor and Palo Alto.

Source: September 2005 FTE/Caseload Report

TABLE 2-6. CLINICAL STAFF AND CASELOAD

VISN	SITE NAME	*MEDICAL SUPPORT		CLINICAL FTE	9/05 TOTAL # VETS	9/05 CASELOAD per CLIN FTE^	TEAM TARGET CASELOAD	
		MD	RN				MIN	MAX
1	BEDFORD	Y	Y	9.50	114	12.00	67	143
1	BROCKTON	N	N	4.10	75	18.29	29	62
1	TOGUS	Y	Y	4.00	32	8.00	28	60
1	WEST HAVEN	Y	Y	4.95	64	12.93	35	74
2	ALBANY	Y	Y	3.75	47	12.53	26	56
2	BUFFALO	Y	Y	6.00	63	10.50	42	90
2	CANANDAIGUA	N	Y	9.30	82	8.82	65	140
2	SYRACUSE	Y	Y	3.00	50	16.67	21	45
3	BROOKLYN	N	Y	3.90	48	12.31	27	59
3	HUDSON VALLEY	Y	Y	7.50	79	10.53	53	113
3	NEW JERSEY	N	Y	7.50	85	11.33	53	113
3	NORTHPORT	N	Y	5.80	87	15.00	41	87
4	COATESVILLE	Y	Y	5.60	87	15.54	39	84
4	LEBANON	N	Y	3.50	20	5.71	25	53
4	PHILADELPHIA	N	Y	2.75	33	12.00	19	41
4	PITTSBURGH	Y	Y	7.50	117	15.60	53	113
5	BALTIMORE	Y	Y	3.50	24	6.86	25	53
5	MARTINSBURG	N	Y	3.50	40	11.43	25	53
5	PERRY POINT	Y	Y	4.25	63	14.82	30	64
5	WASHINGTON, DC	Y	Y	4.00	46	11.50	28	60
6	FAYETTEVILLE	Y	Y	3.50	34	9.71	25	53
6	HAMPTON	Y	Y	4.50	55	12.22	32	68
6	SALEM	Y	Y	1.50	21	14.00	11	23
6	SALISBURY	Y	Y	4.00	60	15.00	28	60
7	ATLANTA	Y	Y	8.50	64	7.53	60	128
7	AUGUSTA	N	Y	5.50	61	11.09	39	83
7	BIRMINGHAM	Y	Y	3.50	35	10.00	25	53
7	CHARLESTON	Y	Y	3.50	33	9.43	25	53
7	COLUMBIA	N	Y	3.50	50	14.29	25	53
7	TUSCALOOSA	Y	Y	4.50	66	14.67	32	68
7	TUSKEGEE	N	Y	4.50	50	11.11	32	68
8	GAINESVILLE	Y	Y	4.00	51	12.75	28	60
8	MIAMI	Y	Y	3.50	80	22.86	25	53
8	TAMPA	N	Y	6.50	44	6.77	46	98
8	WEST PALM BEACH	Y	Y	3.00	22	7.33	21	45
10	AKRON	Y	Y	3.50	34	9.71	25	53
10	CHILLICOTHE	Y	Y	9.00	100	11.11	63	135
10	CINCINNATI	Y	Y	8.50	134	15.76	60	128
10	CLEVELAND	Y	Y	11.50	118	10.26	81	173
10	COLUMBUS	N	Y	3.33	29	8.71	23	50
10	DAYTON	N	Y	9.00	116	12.89	63	135
10	MANSFIELD	Y	Y	4.50	34	7.56	32	68
10	YOUNGSTOWN	Y	Y	4.50	41	9.11	32	68
11	ANN ARBOR	Y	Y	3.50	50	14.29	25	53
11	BATTLE CREEK	Y	Y	5.00	68	13.60	35	75
11	DANVILLE	N	Y	3.50	28	8.00	25	53
11	DETROIT	Y	Y	6.00	79	13.17	42	90
11	NORTHERN INDIANA	N	Y	5.00	71	14.20	35	75
12	CHICAGO-WEST SIDE	Y	Y	5.50	71	12.91	39	83
12	MADISON	Y	Y	3.30	46	13.94	23	50
12	MILWAUKEE	Y	Y	3.00	52	17.33	21	45
12	NORTH CHICAGO	Y	Y	6.50	103	15.85	46	98

TABLE 2-6. CLINICAL STAFF AND CASELOAD

VISN	SITE NAME	*MEDICAL SUPPORT		CLINICAL FTE	9/05 TOTAL # VETS	9/05 CASELOAD per CLIN FTE^	TEAM TARGET CASELOAD	
		MD	RN				MIN	MAX
12	TOMAH	Y	Y	2.25	42	18.67	16	34
15	ST. LOUIS	N	Y	3.50	59	16.86	25	53
15	TOPEKA	Y	Y	6.50	84	12.92	46	98
16	GULF COAST	Y	Y	4.50	35	7.78	32	68
16	HOUSTON	Y	Y	3.50	55	15.71	25	53
16	LITTLE ROCK	Y	Y	4.00	52	13.00	28	60
16	NEW ORLEANS	Y	Y	3.50	48	13.71	25	53
17	DALLAS	N	Y	6.50	73	11.23	46	98
17	SAN ANTONIO	Y	Y	3.00	35	11.67	21	45
17	TEMPLE (WACO)	N	N	4.50	56	12.44	32	68
18	ALBUQUERQUE	N	Y	4.20	68	16.19	29	63
18	PHOENIX	N	Y	5.50	68	12.36	39	83
19	DENVER	N	Y	4.50	64	14.22	32	68
19	FORT HARRISON	N	Y	1.00	43	43.00	7	15
19	GRAND JUNCTION	N	Y	3.50	36	10.29	25	53
19	SALT LAKE CITY	Y	Y	5.25	58	11.05	37	79
19	SHERIDAN	N	Y	1.20	16	13.33	8	18
19	SOUTHERN COLORADO	N	Y	5.50	85	15.45	39	83
20	AMERICAN LAKE	Y	Y	4.00	48	12.00	28	60
20	BOISE	Y	Y	3.00	34	11.33	21	45
20	PORTLAND	Y	Y	6.30	70	11.11	44	95
20	SEATTLE	Y	Y	3.45	59	17.10	24	52
21	PALO ALTO	Y	Y	3.00	36	12.00	21	45
21	SAN FRANCISCO	Y	Y	3.00	40	13.33	21	45
22	GREATER LOS ANGELES	N	Y	5.50	63	11.45	39	83
22	LONG BEACH	Y	Y	3.50	49	14.00	25	53
22	SAN DIEGO	Y	Y	4.00	69	17.25	28	60
23	IOWA CITY	Y	Y	4.00	44	11.00	28	60
23	KNOXVILLE	Y	Y	7.00	77	11.00	49	105
23	MINNEAPOLIS	Y	Y	4.50	64	14.22	32	68
23	OMAHA	Y	Y	3.50	47	13.43	25	53
23	ST.CLOUD	Y	Y	2.50	32	12.80	18	38
ALL SITES		67.9%	97.6%	392.68	4865	12.39	2749	5890
SITE AVERAGE				4.67	57.9	12.87	33.0	70.4
SITE STD. DEV				1.94	24.5	4.48	13.7	29.2

* Medical Support assigned to team: N=No, Y=Yes

+ Target Caseload ranges based on client:clinical FTE levels of 7:1 Minimum and 15:1 Maximum

^ Shaded values fall outside minimum standard caseload range (7.0-15.0 clients per clinical FTE) or deviate from expected staffing.

~MHICM teams (N=8) with insufficient data to be included in this Report: Durham, Louisville, Memphis, Tennessee Valley, Indianapolis, Hines, Tucson, and Loma Linda. No signed reports from Ann Arbor and Palo Alto.

Source: September 2005 FTE/Caseload Report

TABLE 2-7. DEMOGRAPHIC CHARACTERISTICS OF VETERANS AT INTAKE

	OVERALL	GM+S	NP
	(N= 5,696)	(N= 3,397)	(N= 2,299)
	#	#	#
AGE (Mean Years)	50.6	50.6	50.7
GENDER	%	%	%
Male	90.7	89.7	92.4
Female	9.3	10.3	7.6
RACE			
White, non-Hisp.	65.2	61.2	71.7
African-America	27.6	30.3	23.3
Hispanic	3.9	4.8	2.6
Other	1.0	1.2	0.7
Alaskan /American Indian	0.8	1.0	0.5
Asian or Pacific Islander	1.5	1.6	1.2
MARITAL STATUS			
Never Married	44.7	42.2	48.8
Divorced	32.6	32.5	32.9
Married	11.3	12.9	8.7
Separated	6.8	7.4	5.7
Widowed	3.6	3.9	3.2
Living w/signif. other	0.9	1.1	0.6
COMBAT EXPOSURE	21.8	21.8	21.6
EMPLOYMENT LAST 3 YR			
Disability	73.8	74.1	73.2
Hosp./Controlled Environment	3.2	1.5	5.9
Retired	5.2	5.8	4.3
Unemployed	4.4	4.2	4.8
Part-time/Irregular work	5.5	5.9	4.9
Full-time work	4.6	4.9	4.2
Part-time Regular work	2.2	2.5	1.8
Student/Volunteer work	1.1	1.1	0.9

Source: Client Interviews

TABLE 2-8. ENTRY CRITERIA INFORMATION

	OVERALL	GMS	NP
	(N= 5,696)	(N= 3,397)	(N= 2,299)
	#	#	#
MEAN HOSPITAL DAYS (1 Yr Pre)	74.5	68.4	100.0
	%	%	%
INPT. PSYCH.UNIT REFERRAL	32.2	32.1	32.5
PRIM.PSYCHIATRIC DIAGNOSIS	100.0	100.0	100.0
GTE 30 DAYS IN HOSPITAL	72.6	68.9	78.5
DUAL DIAGNOSIS AT ENTRY	20.1	19.1	21.7
DIAGNOSIS			
Schizophrenia	52.2	50.8	54.4
Schizoaffective	20.9	22.0	19.2
Bipolar Disorder	17.8	18.0	17.5
Affective Disorder	6.7	7.1	6.2
PTSD	9.3	9.3	9.3
Psychosis/Other	3.8	4.1	3.2
Other Disorder	7.2	7.6	6.5
Anxiety Disorder	4.4	4.6	4.0
Alcohol Abuse/Dependence	15.3	13.7	17.8
Organic Brain Syndrome	1.4	1.2	1.7
Dementia	1.3	1.1	1.6
Borderline Personality Disorder	3.3	3.4	3.0
Drug Abuse/Dependence	11.1	11.4	10.7
Adjustment Disorder	0.9	0.9	1.0
DISABILITY/PENSION			
DISABILITY/PENSION	93.9	93.6	94.3
SC DISABILITY	55.4	55.6	55.0
NSC PENSION	18.4	17.1	20.4
SSI	14.4	15.8	12.2
SSDI	49.4	49.5	49.4
PAYEE	46.2	43.3	50.7

Source: Client Interviews

TABLE 2-9. RECEIPT OF DISABILITY COMPENSATION OR PENSION INCOME

VISN SITE	VA	NSC	SSI	SSDI	REP	ANY
	COMPENSATION	PENSION			PAYEE	DISABILITY
	%	%	%	%	%	%
1 Bedford	43.0	19.2	15.8	34.8	31.9	83.1
1 Brockton	48.2	13.0	8.9	50.0	49.1	96.4
1 Togus	87.9	12.5	12.5	45.5	42.4	100.0
1 West Haven	41.7	17.6	11.4	52.8	33.3	88.9
2 Albany	60.0	7.1	14.8	55.2	44.4	90.0
2 Buffalo	44.3	16.7	14.1	50.0	38.8	90.0
2 Canandaigua	55.7	23.7	13.3	58.3	65.6	96.7
2 Syracuse	32.6	16.7	19.0	46.5	30.2	83.7
3 Brooklyn	54.2	17.9	14.0	38.2	15.5	91.5
3 Hudson Valley	63.8	15.8	10.3	58.6	75.9	100.0
3 New Jersey	63.7	15.4	10.0	52.8	50.5	98.9
3 Northport	60.9	8.1	11.9	52.2	27.3	93.5
4 Coatesville	65.4	19.8	19.8	41.7	54.7	97.2
4 Lebanon	65.0	20.0	10.5	76.5	70.0	95.0
4 Philadelphia	53.1	16.7	6.5	46.9	32.3	84.4
4 Pittsburgh	50.8	29.2	6.2	42.6	24.2	95.4
5 Baltimore	71.4	7.4	7.4	40.7	57.1	92.9
5 Martinsburg	34.7	28.6	12.8	39.1	14.3	87.8
5 Perry Point	66.2	18.3	5.7	45.7	67.1	97.2
5 Washington, DC	72.3	2.3	17.0	48.9	42.6	100.0
6 Fayetteville	64.7	12.9	12.1	36.4	37.5	94.1
6 Hampton	67.4	28.2	9.5	41.9	30.2	97.7
6 Salem	56.3	12.9	12.5	58.1	40.6	87.5
6 Salisbury	67.9	25.0	3.8	41.5	60.4	100.0
7 Atlanta	92.5	2.0	9.4	61.5	45.3	98.1
7 Augusta	60.3	25.0	7.8	40.3	62.8	98.7
7 Birmingham	42.9	28.1	14.7	45.5	58.8	97.1
7 Charleston	51.4	8.8	11.4	57.1	60.0	94.3
7 Columbia	64.0	8.5	4.0	36.7	58.0	86.0
7 Tuscaloosa	42.6	9.6	20.4	69.8	65.4	92.6
7 Tuskegee	60.0	16.0	18.5	58.2	60.4	96.4
8 Gainesville	68.4	7.1	16.1	62.5	55.4	100.0
8 Miami	54.7	8.0	13.5	47.1	37.3	88.7
8 Tampa	60.0	25.0	8.0	40.0	33.3	96.0
8 West Palm Beach	45.8	17.4	28.6	63.6	26.1	100.0
10 Akron	61.4	22.0	14.3	51.2	37.2	100.0
10 Chillicothe	51.1	27.3	12.6	30.7	62.5	92.2
10 Cincinnati	53.9	11.8	8.9	50.4	31.2	92.9
10 Cleveland	43.8	22.0	23.5	43.5	40.7	94.4
10 Columbus	58.6	25.9	10.7	60.7	46.4	96.6
10 Dayton	50.0	23.0	20.5	43.8	34.2	91.1
10 Mansfield	67.6	9.1	0.0	52.8	78.4	97.3
10 Youngstown	39.5	22.5	40.0	39.0	52.4	86.0
11 Ann Arbor	60.4	12.0	11.5	66.0	54.7	94.3
11 Battle Creek	46.1	23.3	18.9	63.5	56.0	97.4
11 Danville	40.7	7.4	3.7	61.5	38.5	88.9
11 Detroit	62.7	28.0	23.2	58.0	50.6	96.4
11 Northern Indiana	60.9	6.5	21.7	47.8	60.9	95.7
12 Chicago-West Side	44.1	10.2	24.0	45.5	26.9	96.6

VISN SITE	VA COMPENSATION %	NSC PENSION %	SSI %	SSDI %	REP PAYEE %	ANY DISABILITY %
12 Madison	42.9	20.8	12.5	63.3	44.9	91.8
12 Milwaukee	62.7	24.0	19.6	43.1	33.3	100.0
12 North Chicago	40.0	20.2	20.2	47.3	55.0	91.5
12 Tomah	66.7	16.0	23.1	65.4	55.6	96.3
15 St. Louis	50.8	22.4	16.4	49.2	39.7	87.7
15 Topeka	51.3	18.4	2.7	54.1	46.2	87.2
16 Gulf Coast	44.2	25.0	11.5	53.8	34.6	92.3
16 Houston	50.7	12.1	26.1	44.1	55.9	97.1
16 Little Rock	40.4	26.5	9.6	46.2	69.2	98.1
16 New Orleans	68.4	13.0	7.1	57.9	41.8	96.5
17 Dallas	55.0	23.1	10.1	47.4	47.5	92.5
17 San Antonio	57.1	17.9	18.2	54.3	54.3	100.0
17 Temple (Waco)	56.9	20.8	6.9	38.0	40.3	94.4
18 Albuquerque	55.6	15.2	12.5	58.3	37.5	94.4
18 Phoenix	64.8	11.3	18.9	47.7	44.4	96.7
19 Denver	68.8	18.4	12.0	42.9	53.2	97.4
19 Fort Harrison	51.2	35.7	23.8	44.2	31.0	97.7
19 Grand Junction	33.3	13.3	13.3	48.9	15.6	82.2
19 Salt Lake City	70.1	12.9	10.6	63.6	70.1	97.0
19 Sheridan	61.1	25.0	6.3	72.2	23.5	94.4
19 Southern Colorado	70.0	24.4	9.2	46.1	65.6	96.7
20 American Lake	58.5	15.4	9.4	55.8	40.4	90.6
20 Boise	66.7	35.1	32.4	61.5	51.4	100.0
20 Portland	52.5	16.4	16.4	56.7	31.1	93.4
20 Seattle	47.5	22.8	11.9	45.0	49.2	95.1
21 Palo Alto	53.5	12.1	39.1	36.8	70.4	95.8
21 San Francisco	55.6	20.0	20.5	57.8	46.7	95.6
22 Greater Los Angeles	65.2	10.0	22.2	53.8	51.6	90.9
22 Long Beach	65.3	14.9	16.7	55.3	50.0	91.8
22 San Diego	63.2	16.7	18.9	24.7	33.8	85.5
23 Iowa City	47.1	12.0	12.2	46.0	34.0	86.3
23 Knoxville	50.0	33.3	2.2	66.7	48.3	92.2
23 Minneapolis	59.2	17.1	13.0	60.0	44.3	97.2
23 Omaha	50.0	15.9	6.5	56.5	47.8	91.3
23 St.Cloud	53.8	15.8	13.2	60.5	46.2	94.9
ALL SITES	55.5	18.4	14.4	49.4	46.2	93.9
SITE AVERAGE	56.2	17.7	14.2	50.9	46.1	94.0
SITE STD. DEV.	11.1	7.3	7.4	9.9	14.2	4.5

Source: Client Interview

TABLE 2-10. ENTRY CRITERIA INFORMATION BY SITE

VISN	SITE	LIFETIME HOSP GT 2 YRS	YEARS SINCE 1ST HOSP.	GTE 30 DAYS HOSP. YR PREV	PSYCHOTIC DX AT ENTRY	DUAL DIAGNOSIS
		%	#	%	%	%
1	Bedford	32.6	19.5	72.1	69.0	51.4
1	Brockton	58.5	23.9	82.1	92.9	21.4
1	Togus	35.5	25.2	90.9	93.9	
1	West Haven	41.2	18.1	94.4	83.3	19.4
2	Albany	31.0	18.8	66.7	90.0	46.7
2	Buffalo	19.6	24.5	33.9	72.9	27.1
2	Canandaigua	63.8	21.8	85.0	93.4	32.8
2	Syracuse	23.8	19.2	80.5	60.5	16.3
3	Brooklyn	25.5	20.6	84.2	84.7	8.5
3	Hudson Valley	78.8	29.1	89.7	98.3	12.1
3	New Jersey	52.8	25.6	73.0	93.4	29.7
3	Northport	36.4	24.1	97.8	84.8	13.0
4	Coatesville	53.1	24.4	89.4	89.7	27.1
4	Lebanon	55.6	23.1	95.0	100.0	25.0
4	Philadelphia	38.7	19.5	80.6	84.4	9.4
4	Pittsburgh	40.3	23.3	88.0	93.8	7.7
5	Baltimore	42.3	23.8	87.5	92.9	3.6
5	Martinsburg	28.9	21.4	63.8	63.3	42.9
5	Perry Point	89.1	31.0	95.8	98.6	9.9
5	Washington, DC	40.5	19.7	45.2	100.0	25.5
6	Fayetteville	33.3	16.6	53.1	76.5	14.7
6	Hampton	45.2	25.1	76.7	81.4	27.9
6	Salem	50.0	22.4	70.0	84.4	59.4
6	Salisbury	56.0	27.3	83.0	96.2	17.0
7	Atlanta	38.0	21.6	67.9	90.6	5.7
7	Augusta	79.2	23.7	94.8	93.6	2.6
7	Birmingham	46.9	24.9	97.0	91.4	14.3
7	Charleston	35.3	21.4	71.4	77.1	34.3
7	Columbia	37.2	20.8	35.4	92.0	20.0
7	Tuscaloosa	63.0	25.0	98.1	94.4	13.0
7	Tuskegee	26.4	24.9	66.0	85.5	9.1
8	Gainesville	46.2	22.2	70.2	94.7	3.5
8	Miami	29.4	24.1	28.6	84.9	7.5
8	Tampa	29.2	25.9	58.3	100.0	4.0
8	West Palm Beach	19.0	17.8	68.2	83.3	12.5
10	Akron	38.1	24.3	72.1	90.9	15.9
10	Chillicothe	56.1	26.5	59.6	87.8	11.1
10	Cincinnati	19.6	21.8	47.2	84.4	17.0
10	Cleveland	39.6	22.8	90.7	95.1	18.1
10	Columbus	25.0	18.6	66.7	96.6	6.9
10	Dayton	20.9	21.0	29.3	82.3	16.9
10	Mansfield	57.1	25.6	90.9	94.6	24.3
10	Youngstown	22.9	22.0	54.8	88.4	11.6

VISN	SITE	LIFETIME	YEARS SINCE	GTE 30 DAYS	PSYCHOTIC DX	DUAL
		HOSP GT 2 YRS	1ST HOSP.	HOSP. YR PREV	AT ENTRY	DIAGNOSIS
		%	#	%	%	%
11	Ann Arbor	28.3	18.1	69.2	100.0	26.4
11	Battle Creek	68.6	24.4	88.2	93.4	15.8
11	Danville	19.2	21.0	74.1	70.4	77.8
11	Detroit	53.9	23.2	86.6	95.2	18.1
11	Northern Indiana	65.9	27.6	97.8	93.5	17.4
12	Chicago-West Side	27.6	20.4	90.9	88.1	8.5
12	Madison	33.3	22.1	70.8	95.9	16.3
12	Milwaukee	31.3	25.4	24.5	92.2	7.8
12	North Chicago	57.5	23.6	78.9	83.1	22.3
12	Tomah	63.0	29.1	72.0	96.3	37.0
15	St. Louis	24.6	22.3	67.8	76.9	33.8
15	Topeka	44.1	18.3	86.8	92.3	23.1
16	Gulf Coast	30.0	21.8	84.3	82.7	26.9
16	Houston	33.8	24.5	52.9	95.7	29.0
16	Little Rock	26.2	25.8	75.0	94.2	3.8
16	New Orleans	31.9	23.7	60.7	98.2	8.8
17	Dallas	29.3	19.0	87.5	93.8	27.5
17	San Antonio	38.7	20.6	84.4	94.3	14.3
17	Temple (Waco)	60.9	21.1	81.7	90.3	19.4
18	Albuquerque	40.0	21.6	68.1	95.8	5.6
18	Phoenix	30.2	26.0	44.0	82.4	8.8
19	Denver	39.7	21.6	92.2	94.8	29.9
19	Fort Harrison	9.3	19.7	82.9	74.4	23.3
19	Grand Junction	26.7	18.5	51.2	84.4	35.6
19	Salt Lake City	35.5	23.7	43.9	95.5	23.9
19	Sheridan	44.4	21.9	93.8	61.1	55.6
19	Southern Colorado	52.3	28.0	22.5	88.9	10.0
20	American Lake	35.3	19.2	92.3	98.1	18.9
20	Boise	22.9	18.5	42.1	97.4	20.5
20	Portland	29.5	20.4	93.4	90.2	21.3
20	Seattle	28.1	25.7	28.3	85.2	26.2
21	Palo Alto	64.7	27.6	80.3	97.2	33.8
21	San Francisco	38.6	22.7	86.4	93.3	31.1
22	Greater Los Angeles	58.1	20.6	93.8	89.4	24.2
22	Long Beach	31.0	19.1	79.6	87.8	10.2
22	San Diego	29.7	19.6	93.2	73.7	21.1
23	Iowa City	28.0	24.1	62.0	78.4	15.7
23	Knoxville	47.6	21.3	92.2	85.6	15.6
23	Minneapolis	50.7	24.2	97.1	98.6	7.0
23	Omaha	31.1	21.5	61.4	89.1	30.4
23	St.Cloud	47.2	24.3	51.3	82.1	35.9
ALL SITES		41.1	22.9	72.6	88.5	20.1
SITE AVERAGE		40.4	22.7	73.0	88.5	20.9
SITE STD. DEV.		15.5	3.0	20.0	9.0	13.5

^ Shaded values do not meet the minimum standard (50% with 30+ hospital days in year prior to entry.)
Source: Client Interview

TABLE 2-11. CLINICAL STATUS AT ENTRY

VISN	SITE	INPATIENT AT ENTRY %	LOW IADL %	BPRS MEAN #	GAF MEAN #
1	Bedford	38.0	44.0	37.3	40.9
1	Brockton	14.3	48.1	34.7	31.5
1	Togus	54.5	36.4	32.8	41.0
1	West Haven	88.9	41.7	39.2	31.8
2	Albany	6.7	33.3	48.0	37.9
2	Buffalo	7.4	61.9	44.1	36.3
2	Canandaigua	4.9	39.3	40.1	33.9
2	Syracuse	32.6	65.1	42.8	43.3
3	Brooklyn	29.3	53.4	40.6	41.0
3	Hudson Valley	70.7	66.7	44.9	39.8
3	New Jersey	54.9	55.7	40.5	42.9
3	Northport	39.1	64.4	41.1	46.7
4	Coatesville	29.9	69.5	40.4	41.3
4	Lebanon	0.0	40.0	53.6	37.6
4	Philadelphia	6.3	43.8	41.6	43.3
4	Pittsburgh	44.2	42.9	34.5	39.0
5	Baltimore	39.3	60.7	46.1	43.1
5	Martinsburg	6.4	34.7	35.0	42.1
5	Perry Point	53.5	62.3	45.1	38.6
5	Washington, DC	30.4	42.6	47.6	43.5
6	Fayetteville	5.9	48.5	42.8	46.0
6	Hampton	4.7	48.8	40.1	40.8
6	Salem	0.0	27.6	35.0	45.0
6	Salisbury	32.1	57.4	44.0	39.7
7	Atlanta	69.8	48.1	37.9	43.7
7	Augusta	60.3	50.0	30.6	42.7
7	Birmingham	8.6	50.0	35.9	43.8
7	Charleston	51.4	65.7	47.1	31.7
7	Columbia	8.0	68.1	39.8	45.7
7	Tuscaloosa	18.5	68.6	28.0	42.9
7	Tuskegee	45.5	61.8	39.0	47.5
8	Gainesville	40.4	57.1	49.9	41.6
8	Miami	26.9	55.8	37.2	39.4
8	Tampa	16.0	47.8	37.2	51.2
8	West Palm Beach	13.6	54.2	45.4	40.0
10	Akron	45.5	58.1	43.9	38.6
10	Chillicothe	38.2	25.0	33.4	41.9
10	Cincinnati	19.3	46.8	37.3	45.7
10	Cleveland	47.9	40.0	35.4	36.7
10	Columbus	17.9	44.8	38.6	46.0
10	Dayton	12.1	38.7	39.8	46.0
10	Mansfield	2.8	78.8	33.6	37.2
10	Youngstown	4.7	59.5	38.5	45.2
11	Ann Arbor	30.2	61.2	41.2	36.2
11	Battle Creek	15.8	66.2	37.9	45.1
11	Danville	0.0	42.3	30.0	48.9
11	Detroit	61.0	56.4	32.4	44.2
11	Northern Indiana	82.6	60.5	40.6	46.0
12	Chicago-West Side	52.5	54.2	42.3	43.6
12	Madison	43.8	41.7	36.9	43.2

VISN	SITE	INPATIENT AT ENTRY %	LOW IADL %	BPRS MEAN #	GAF MEAN #
12	Milwaukee	0.0	64.7	51.6	42.4
12	North Chicago	36.2	39.8	33.4	35.2
12	Tomah	0.0	26.9	40.7	37.4
15	St. Louis	40.0	43.5	58.3	44.5
15	Topeka	43.6	58.3	44.3	39.4
16	Gulf Coast	11.5	48.1	35.4	48.3
16	Houston	27.5	65.2	42.3	40.8
16	Little Rock	11.5	65.2	36.8	25.9
16	New Orleans	43.9	49.1	46.0	34.4
17	Dallas	75.0	56.3	37.9	39.6
17	San Antonio	60.0	57.6	46.5	37.5
17	Temple (Waco)	36.1	34.7	40.5	40.7
18	Albuquerque	41.7	26.8	36.3	38.1
18	Phoenix	12.4	41.8	45.8	44.5
19	Denver	63.6	52.0	37.1	37.3
19	Fort Harrison	0.0	53.5	45.2	48.6
19	Grand Junction	65.9	42.2	57.1	35.2
19	Salt Lake City	22.4	47.7	55.9	34.3
19	Sheridan	47.1	38.9	50.2	47.9
19	Southern Colorado	3.3	44.4	33.5	42.8
20	American Lake	17.0	55.8	46.9	37.9
20	Boise	5.3	48.7	37.0	39.9
20	Portland	52.5	67.9	40.8	28.9
20	Seattle	4.9	59.0	54.7	39.2
21	Palo Alto	12.7	72.9	48.8	40.4
21	San Francisco	24.4	59.1	43.3	37.8
22	Greater Los Angeles	60.6	56.9	49.6	45.2
22	Long Beach	6.1	42.6	41.6	45.4
22	San Diego	2.7	35.6	40.8	39.3
23	Iowa City	70.6	59.2	37.7	28.5
23	Knoxville	12.2	55.1	36.8	34.8
23	Minneapolis	70.6	32.8	48.0	33.8
23	Omaha	30.4	54.3	37.8	35.2
23	St.Cloud	28.2	36.4	44.9	43.3
ALL SITES		32.2	50.5	40.5	40.4
SITE AVERAGE		30.6	51.0	41.3	40.6
SITE STD. DEV.		23.4	11.8	6.2	5.0

Shaded values are greater than or equal to 50..

Source: Client Interview

TABLE 2-12. MHICM PROGRAM TENURE

VISN	SITE	TOTAL VETS FY05	VETS DISCHARGED #	VETS DISCHARGED %	MEAN DAYS IN PROGRAM PER VET
1	Bedford	142	23	16.2%	1,763
1	Brockton	80	6	7.5%	1,482
1	Togus	35	4	11.4%	1,975
1	West Haven	67	4	6.0%	1,681
2	Albany	54	6	11.1%	1,069
2	Buffalo	92	22	23.9%	1,156
2	Canandaigua	105	22	21.0%	1,662
2	Syracuse	51	4	7.8%	1,418
3	Brooklyn	60	13	21.7%	1,509
3	Hudson Valley	90	10	11.1%	1,994
3	New Jersey	95	6	6.3%	1,537
3	Northport	114	23	20.2%	512
4	Coatesville	109	22	20.2%	1,801
4	Lebanon	20	3	15.0%	298
4	Philadelphia	32	2	6.3%	355
4	Pittsburgh	132	16	12.1%	1,681
5	Baltimore	28	5	17.9%	846
5	Martinsburg	49	8	16.3%	360
5	Perry Point	71	7	9.9%	2,227
5	Washington, DC	49	2	<u>4.1%</u>	701
6	Fayetteville	36	1	<u>2.8%</u>	713
6	Hampton	63	7	11.1%	710
6	Salem	38	14	36.8%	494
6	Salisbury	61	1	<u>1.6%</u>	1,252
7	Atlanta	69	4	5.8%	2,070
7	Augusta	78	14	17.9%	2,199
7	Birmingham	39	2	<u>5.1%</u>	520
7	Charleston	35	2	5.7%	392
7	Columbia	57	10	17.5%	371
7	Tuscaloosa	74	8	10.8%	734
7	Tuskegee	61	10	16.4%	1,568
8	Gainesville	57	4	7.0%	2,476
8	Miami	89	8	9.0%	565
8	Tampa	55	9	16.4%	561
8	West Palm Beach	25	2	8.0%	230
10	Akron	44	8	18.2%	946
10	Chillicothe	113	8	7.1%	1,847
10	Cincinnati	147	6	<u>4.1%</u>	975
10	Cleveland	146	25	17.1%	1,129
10	Columbus	29	0	<u>0.0%</u>	1,149
10	Dayton	128	13	10.2%	789
10	Mansfield	38	3	7.9%	478
10	Youngstown	44	3	6.8%	924
11	Ann Arbor	54	7	13.0%	1,951
11	Battle Creek	78	16	20.5%	1,655
11	Danville	42	13	31.0%	302
11	Detroit	88	14	15.9%	1,729
11	Northern Indiana	84	8	9.5%	549
12	Chicago-West Side	73	3	<u>4.1%</u>	1,549

VISN	SITE	TOTAL VETS FY05	VETS DISCHARGED #	VETS DISCHARGED %	MEAN DAYS IN PROGRAM PER VET
12	Madison	50	3	6.0%	1,915
12	Milwaukee	53	2	3.8%	713
12	North Chicago	135	28	20.7%	1,817
12	Tomah	52	9	17.3%	463
15	St. Louis	67	8	11.9%	500
15	Topeka	104	15	14.4%	498
16	Gulf Coast	53	12	22.6%	784
16	Houston	69	9	13.0%	1,105
16	Little Rock	58	6	10.3%	998
16	New Orleans	60	11	18.3%	880
17	Dallas	81	8	9.9%	2,000
17	San Antonio	38	3	7.9%	367
17	Temple (Waco)	73	10	13.7%	1,782
18	Albuquerque	73	5	6.8%	503
18	Phoenix	103	28	27.2%	569
19	Denver	77	13	16.9%	1,848
19	Fort Harrison	51	10	19.6%	672
19	Grand Junction	45	9	20.0%	1,128
19	Salt Lake City	71	12	16.9%	1,093
19	Sheridan	18	2	11.1%	1,286
19	Southern Colorado	93	6	6.5%	1,353
20	American Lake	54	8	14.8%	2,074
20	Boise	40	5	12.5%	2,145
20	Portland	80	10	12.5%	1,084
20	Seattle	63	6	9.5%	1,391
21	Palo Alto	73	4	5.5%	804
21	San Francisco	46	4	8.7%	1,870
22	Greater Los Angeles	69	7	10.1%	2,373
22	Long Beach	49	0	0.0%	374
22	San Diego	76	6	7.9%	499
23	Iowa City	52	8	15.4%	729
23	Knoxville	90	15	16.7%	1,232
23	Minneapolis	72	7	9.7%	2,049
23	Omaha	48	2	4.2%	497
23	St.Cloud	40	7	17.5%	1,076
ALL SITES		5,696	729	12.8 %	1,295
SITE AVERAGE		67.8	9	12.4 %	1,159
SITE STD. DEV.		29.4	6	6.8 %	616

^Shaded values exceed the threshold level (20%) for the minimum program standard.

Source: Clinical Progrss Reports as of 9/30/05

TABLE 2-13. PATTERN OF SERVICE DELIVERY

VISN	SITE	Total VETS #	CONTACT FREQUENCY % WEEKLY OR MORE		INTENSITY 1 OR MORE HRS / WEEK CONTACT	LOCATION 60% OR MORE CONTACT IN COMMUNITY
			FACE-FACE	TELEPHONE		
1	Bedford	142	93.0	69.7	76.1	79.6
1	Brockton	80	93.8	41.3	50.0	87.5
1	Togus	35	88.6	71.4	80.0	100.0
1	West Haven	67	88.1	62.7	64.2	86.6
2	Albany	54	74.1	33.3	51.9	63.0
2	Buffalo	92	75.0	35.9	44.6	91.3
2	Canandaigua	105	75.2	28.6	73.3	56.2
2	Syracuse	51	86.3	54.9	70.6	62.7
3	Brooklyn	60	80.0	63.3	60.0	86.7
3	Hudson Valley	90	88.9	10.0	7.8	87.8
3	New Jersey	95	89.5	38.9	52.6	95.8
3	Northport	114	88.6	31.6	52.6	90.4
4	Coatesville	109	87.2	56.0	51.4	67.0
4	Lebanon	20	85.0	80.0	80.0	85.0
4	Philadelphia	32	100.0	78.1	59.4	100.0
4	Pittsburgh	132	85.6	40.9	29.5	78.8
5	Baltimore	28	96.4	64.3	78.6	92.9
5	Martinsburg	49	91.8	75.5	51.0	65.3
5	Perry Point	71	98.6	35.2	78.9	98.6
5	Washington, DC	49	93.9	83.7	93.9	75.5
6	Fayetteville	36	88.9	58.3	66.7	97.2
6	Hampton	63	95.2	49.2	68.3	90.5
6	Salem	38	81.6	28.9	47.4	86.8
6	Salisbury	61	100.0	77.0	100.0	100.0
7	Atlanta	69	95.7	82.6	65.2	91.3
7	Augusta	78	83.3	34.6	66.7	79.5
7	Birmingham	39	94.9	64.1	84.6	94.9
7	Charleston	35	100.0	88.6	88.6	97.1
7	Columbia	57	98.2	68.4	56.1	96.5
7	Tuscaloosa	74	90.5	45.9	51.4	91.9
7	Tuskegee	61	93.4	37.7	52.5	96.7
8	Gainesville	57	89.5	70.2	71.9	98.2
8	Miami	89	97.8	75.3	76.4	96.6
8	Tampa	55	94.5	60.0	70.9	92.7
8	West Palm Beach	25	100.0	84.0	96.0	100.0
10	Akron	44	88.6	50.0	34.1	93.2
10	Chillicothe	113	99.1	61.1	73.5	98.2
10	Cincinnati	147	95.9	73.5	55.1	98.6
10	Cleveland	146	95.9	50.7	40.4	94.5
10	Columbus	29	86.2	65.5	62.1	96.6
10	Dayton	128	87.5	63.3	67.2	96.9
10	Mansfield	38	97.4	60.5	73.7	100.0
10	Youngstown	44	97.7	54.5	40.9	97.7
11	Ann Arbor	54	59.3	53.7	50.0	98.1
11	Battle Creek	78	87.2	34.6	34.6	97.4
11	Danville	42	90.5	50.0	64.3	92.9
11	Detroit	88	62.5	38.6	35.2	94.3
11	Northern Indiana	84	98.8	19.0	83.3	98.8

VISN	SITE	Total VETS #	CONTACT FREQUENCY		INTENSITY	LOCATION
			% WEEKLY OR MORE		1 OR MORE	60% OR MORE
			FACE-FACE	TELEPHONE	HRS / WEEK CONTACT	CONTACT IN COMMUNITY
12	Chicago-West Side	73	97.3	42.5	<u>90.4</u>	95.9
12	Madison	50	94.0	38.0	64.0	82.0
12	Milwaukee	53	96.2	50.9	<u>86.8</u>	<u>100.0</u>
12	North Chicago	135	85.9	37.8	66.7	88.1
12	Tomah	52	86.5	67.3	71.2	76.9
15	St. Louis	67	85.1	50.7	49.3	89.6
15	Topeka	104	92.3	41.3	64.4	81.7
16	Gulf Coast	53	88.7	64.2	60.4	90.6
16	Houston	69	94.2	36.2	78.3	94.2
16	Little Rock	58	96.6	62.1	70.7	96.6
16	New Orleans	60	80.0	36.7	65.0	90.0
17	Dallas	81	91.4	42.0	27.2	88.9
17	San Antonio	38	100.0	68.4	<u>89.5</u>	94.7
17	Temple (Waco)	73	97.3	97.3	<u>82.2</u>	94.5
18	Albuquerque	73	94.5	79.5	<u>93.2</u>	97.3
18	Phoenix	103	83.5	58.3	51.5	91.3
19	Denver	77	88.3	49.4	61.0	92.2
19	Fort Harrison	51	72.5	41.2	49.0	80.4
19	Grand Junction	45	82.2	80.0	75.6	77.8
19	Salt Lake City	71	94.4	43.7	80.3	95.8
19	Sheridan	18	100.0	83.3	<u>83.3</u>	94.4
19	Southern Colorado	93	97.8	68.8	73.1	<u>100.0</u>
20	American Lake	54	94.4	55.6	57.4	92.6
20	Boise	40	80.0	65.0	70.0	92.5
20	Portland	80	81.3	40.0	68.8	96.3
20	Seattle	63	88.9	61.9	65.1	88.9
21	Palo Alto	73	95.9	86.3	<u>89.0</u>	87.7
21	San Francisco	46	95.7	28.3	50.0	95.7
22	Greater Los Angeles	69	84.1	71.0	81.2	84.1
22	Long Beach	49	98.0	79.6	<u>85.7</u>	98.0
22	San Diego	76	97.4	73.7	72.4	97.4
23	Iowa City	52	90.4	65.4	55.8	98.1
23	Knoxville	90	92.2	64.4	61.1	95.6
23	Minneapolis	72	83.3	31.9	38.9	98.6
23	Omaha	48	89.6	47.9	52.1	97.9
23	St.Cloud	40	100.0	37.5	52.5	95.0
ALL SITES		5696	89.9	53.9	62.5	90.3
SITE AVERAGE		67.8	90.2	56.0	64.5	90.8
SITE STD. DEV.		29.4	8.2	18.2	17.5	9.4

~Shaded values do not meet the minimum standard of 50% or more contact in community.

Bold/Underlined values represent positive outliers.

Source: Clinical Progress Reports as of 9/30/05

TABLE 2-14. OUTPATIENT CLINIC VISITS

VISN	SITE	MEAN CONTACTS per VET:12 MONTH					FY 2005 MEAN AMOUNT OF TIME IN PGM	ADJUSTED	ADJUSTED
		TOTAL VETS	FACE:FACE		FACE:FACE INDIVIDUAL GROUP	FACE-FACE		FACE-FACE	
		SEEN	TOTAL TELEPHONE	CONTACTS/		CONTACTS/			
								VETERAN	WK/VETERAN^
1	Bedford	133	88.74	7.53	75.83	5.38	0.82	98.9	<u>1.90</u>
1	Brockton	80	48.26	2.68	45.59	0.00	0.87	52.3	1.01
1	Togus	35	56.77	7.17	49.60	0.00	0.80	62.2	1.20
1	West Haven	67	88.84	18.78	70.00	0.00	0.89	78.9	1.52
2	Albany	53	91.96	4.15	87.81	0.00	0.87	100.9	<u>1.94</u>
2	Buffalo	84	36.64	1.43	35.20	0.01	0.79	44.5	0.86
2	Canandaigua	97	81.46	2.98	78.48	0.00	0.83	94.4	<u>1.82</u>
2	Syracuse	48	52.69	4.23	47.71	0.75	0.82	58.9	1.13
3	Brooklyn	60	34.87	4.50	30.33	0.02	0.81	37.6	0.72
3	Hudson Valley	84	66.44	3.29	63.15	0.00	0.92	68.8	1.32
3	New Jersey	94	53.65	3.16	50.07	0.00	0.88	56.6	1.09
3	Northport	112	47.71	2.41	45.25	0.00	0.81	56.1	1.08
4	Coatesville	103	62.91	2.73	57.35	1.57	0.78	75.6	1.45
4	Lebanon	20	70.75	12.00	54.00	0.00	0.67	81.0	1.56
4	Philadelphia	32	63.50	0.34	63.09	0.00	0.58	109.4	<u>2.10</u>
4	Pittsburgh	132	36.23	1.44	34.79	0.00	0.87	40.1	0.77
5	Baltimore	26	44.42	0.31	44.12	0.00	0.67	65.4	1.26
5	Martinsburg	49	46.22	7.31	38.92	0.00	0.69	56.6	1.09
5	Perry Point	69	64.61	0.10	64.49	0.01	0.92	70.4	1.35
5	Washington, DC	49	60.27	5.76	36.94	17.57	0.52	104.5	<u>2.01</u>
6	Fayetteville	35	62.91	5.57	54.94	2.40	0.84	68.3	1.31
6	Hampton	61	85.93	3.39	73.16	9.31	0.81	101.4	<u>1.95</u>
6	Salem	30	38.47	2.00	36.20	0.00	0.68	53.3	1.03
6	Salisbury	60	32.35	0.17	32.18	0.00	0.66	48.7	0.94
7	Atlanta	67	67.93	1.67	66.25	0.00	0.78	84.5	1.63
7	Augusta	76	61.05	0.04	61.01	0.00	0.84	72.3	1.39
7	Birmingham	39	79.44	0.03	78.56	0.85	0.80	99.3	<u>1.91</u>
7	Charleston	35	67.66	6.89	60.77	0.00	0.76	80.3	1.54
7	Columbia	55	36.47	1.75	34.73	0.00	0.69	50.2	0.97
7	Tuscaloosa	73	64.30	1.68	62.62	0.00	0.83	75.3	1.45
7	Tuskegee	60	55.18	2.88	52.27	0.03	0.77	67.6	1.30
8	Gainesville	57	81.82	3.98	77.84	0.00	0.94	82.9	1.59
8	Miami	85	53.91	2.29	49.69	1.92	0.74	70.1	1.35
8	Tampa	52	56.35	6.08	50.27	0.00	0.75	67.3	1.29
8	West Palm Beach	25	58.12	11.64	46.24	0.24	0.53	88.3	1.70
10	Akron	43	60.44	0.00	60.40	0.02	0.78	77.8	1.50
10	Chillicothe	110	48.84	0.92	47.90	0.00	0.76	63.1	1.21
10	Cincinnati	143	40.34	0.51	39.83	0.00	0.84	47.5	0.91
10	Cleveland	139	56.81	0.00	56.81	0.00	0.79	72.2	1.39
10	Columbus	29	70.17	8.48	61.69	0.00	0.88	70.2	1.35
10	Dayton	122	49.29	0.00	49.29	0.00	0.86	57.5	1.11
10	Mansfield	38	66.89	0.00	66.71	0.00	0.84	79.5	1.53
10	Youngstown	44	68.30	0.00	68.30	0.00	0.91	75.1	1.44
11	Ann Arbor	53	74.62	6.74	67.89	0.00	0.80	84.6	1.63
11	Battle Creek	78	55.85	0.68	52.82	0.00	0.85	61.9	1.19
11	Danville	41	97.95	3.61	93.78	0.56	0.71	132.0	<u>2.54</u>
11	Detroit	86	35.06	0.00	35.06	0.00	0.87	40.4	0.78
11	Northern Indiana	83	74.77	0.00	73.82	0.92	0.89	84.3	1.62
12	Chicago-West Side	69	68.67	2.30	66.36	0.00	0.90	73.4	1.41
12	Madison	50	145.28	0.06	145.22	0.00	0.93	155.8	<u>3.00</u>
12	Milwaukee	53	57.08	0.68	47.57	8.83	0.74	76.7	1.47
12	North Chicago	133	84.02	2.33	81.68	0.01	0.83	98.8	<u>1.90</u>

VISN	SITE	TOTAL VETS SEEN	MEAN CONTACTS per VET:12 MONTH				FY 2005 MEAN AMOUNT OF TIME IN PGM	ADJUSTED	ADJUSTED
			TOTAL	TELEPHONE	FACE:FACE INDIVIDUAL	GROUP		FACE-FACE CONTACTS/ VETERAN	FACE-FACE CONTACTS/ WK/VETERAN^
12	Tomah	51	110.24	2.98	107.25	0.00	0.83	129.0	<u>2.48</u>
15	St. Louis	67	54.22	11.96	38.61	3.66	0.79	53.8	1.04
15	Topeka	102	109.86	3.16	106.63	0.00	0.84	126.4	<u>2.43</u>
16	Gulf Coast	52	52.79	11.13	41.65	0.00	0.75	55.5	1.07
16	Houston	67	43.96	1.40	42.55	0.00	0.82	51.7	0.99
16	Little Rock	57	91.00	9.67	68.74	0.00	0.80	85.8	1.65
16	New Orleans	55	34.40	0.80	33.60	0.00	0.80	42.1	0.81
17	Dallas	80	66.34	0.04	66.30	0.00	0.86	77.0	1.48
17	San Antonio	36	76.39	4.42	71.67	0.00	0.82	87.4	1.68
17	Temple (Waco)	62	63.08	0.02	63.06	0.00	0.68	92.1	1.77
18	Albuquerque	70	121.41	36.44	84.97	0.00	0.91	93.8	<u>1.80</u>
18	Phoenix	97	35.62	1.06	34.55	0.00	0.69	50.3	0.97
19	Denver	73	46.08	0.05	46.03	0.00	0.91	50.6	0.97
19	Fort Harrison*	0	62.00	0.00	62.00	0.00	0.82	75.7	1.46
19	Grand Junction	44	62.50	4.64	57.86	0.00	0.85	67.9	1.31
19	Salt Lake City	71	58.14	0.18	57.94	0.00	0.78	74.5	1.43
19	Sheridan	18	42.50	2.11	40.39	0.00	0.86	47.2	0.91
19	Southern Colorado	86	62.45	1.48	60.58	0.38	0.90	68.0	1.31
20	American Lake	54	45.54	0.15	45.39	0.00	0.85	53.6	1.03
20	Boise	39	27.46	0.05	21.23	6.18	0.95	28.7	0.55
20	Portland	78	70.12	2.44	66.90	0.00	0.80	83.2	1.60
20	Seattle	59	42.31	1.14	41.17	0.00	0.82	50.3	0.97
21	Palo Alto	73	44.03	0.92	43.11	0.00	0.70	61.3	1.18
21	San Francisco	46	63.33	0.46	62.87	0.00	0.90	70.2	1.35
22	Greater Los Angeles	62	50.32	4.97	45.35	0.00	0.80	56.9	1.09
22	Long Beach	49	64.39	3.80	59.71	0.86	0.68	89.7	1.72
22	San Diego	75	50.07	4.12	44.12	1.83	0.72	63.7	1.22
23	Iowa City	49	45.37	0.31	45.06	0.00	0.82	55.1	1.06
23	Knoxville	87	57.22	4.03	52.98	0.00	0.86	61.6	1.18
23	Minneapolis	71	51.58	4.39	47.17	0.00	0.89	53.3	1.02
23	Omaha	47	49.77	0.64	47.32	1.81	0.84	58.7	1.13
23	St.Cloud	35	36.34	0.00	36.14	0.00	0.85	42.5	0.82
ALL SITES		5463	60.13	3.18	55.78	0.71	0.80	70.9	1.35
SITE AVERAGE		65.04	61.24	3.42	56.76	0.78	0.80	71.80	1.36
SITE STD. DEV.		28.88	20.67	5.03	19.31	2.50	0.09	22.58	0.43

^Shaded values do not meet the minimum standard of at least 1 face-to-face contact per client per week.

Bold /Underlined values exceed one standard deviation from the mean in desired direction.

* Data for this site were provided by the contracted state agency.

Source: Outpatient clinic visits entered under DSS Identifiers 546 and 552 between 10/01/04 and 9/30/05.

TABLE 2-15A. THERAPEUTIC SERVICES

VISN	SITE	FOLLOW- UP VETS #	SUPPORTIVE CONTACT %	ACTIVE MONITOR %	REHABIL- ITATION %	PSYCHOTHER. RELATIONSHIP %	SOCIAL/REC. ACTIVITIES %	CRISIS INTERVENT %
1	Bedford	142	100.0	96.7	55.6	98.9	70.0	72.2
1	Brockton	80	100.0	98.6	50.0	100.0	57.1	58.6
1	Togus	35	96.8	96.8	<u>77.4</u>	100.0	35.5	6.5
1	West Haven	67	98.2	98.2	68.4	96.4	61.4	78.9
2	Albany	54	93.8	100.0	56.3	91.7	47.9	45.8
2	Buffalo	92	94.1	95.7	25.7	67.6	43.5	51.4
2	Canandaigua	105	92.7	93.7	66.3	88.4	84.2	43.2
2	Syracuse	51	100.0	100.0	<u>78.9</u>	36.8	57.9	73.7
3	Brooklyn	60	95.0	90.0	40.0	67.5	17.5	85.0
3	Hudson Valley	90	90.6	90.6	<u>78.8</u>	84.7	88.2	89.3
3	New Jersey	95	100.0	97.5	48.1	92.6	72.8	63.0
3	Northport	114	94.9	97.0	26.3	89.9	46.5	62.6
4	Coatesville	109	98.6	94.6	20.3	67.6	52.7	71.6
4	Lebanon	20	90.9	90.9	40.0	81.8	54.5	72.7
4	Philadelphia	32	100.0	100.0	20.0	100.0	100.0	73.3
4	Pittsburgh	132	95.3	100.0	23.4	99.1	11.2	43.0
5	Baltimore	28	100.0	93.3	53.3	66.7	53.3	66.7
5	Martinsburg	49	100.0	96.8	64.5	77.4	41.9	61.3
5	Perry Point	71	100.0	100.0	65.2	76.1	89.6	55.2
5	Washington, DC	49	94.7	94.7	68.4	100.0	78.9	89.5
6	Fayetteville	36	100.0	96.6	24.1	86.2	93.1	79.3
6	Hampton	63	98.0	96.1	41.2	100.0	60.0	92.2
6	Salem	38	100.0	96.9	31.3	93.8	15.6	93.8
6	Salisbury	61	100.0	100.0	<u>85.7</u>	100.0	100.0	100.0
7	Atlanta	69	100.0	100.0	36.8	89.5	26.3	71.1
7	Augusta	78	85.9	85.9	66.2	84.5	78.9	76.1
7	Birmingham	39	100.0	100.0	28.0	100.0	92.0	92.0
7	Charleston	35	100.0	100.0	46.2	100.0	84.6	69.2
7	Columbia	57	100.0	100.0	3.1	87.5	68.8	96.9
7	Tuscaloosa	74	100.0	100.0	73.1	98.1	78.8	71.2
7	Tuskegee	61	97.5	97.5	65.0	78.9	70.0	70.0
8	Gainesville	57	98.2	98.2	54.5	100.0	96.4	69.1
8	Miami	89	93.9	95.9	46.9	91.8	91.8	69.4
8	Tampa	55	97.6	97.6	19.5	92.5	41.5	73.2
8	West Palm Beach	25	100.0	100.0	60.0	86.7	93.3	100.0
10	Akron	44	100.0	97.1	28.6	94.3	71.4	48.6
10	Chillicothe	113	98.6	95.8	44.4	86.1	76.4	62.5
10	Cincinnati	147	98.0	99.0	70.4	63.3	72.4	79.6
10	Cleveland	146	97.2	96.2	24.5	76.4	26.7	52.8
10	Columbus	29	95.0	90.5	38.1	85.7	61.9	42.9
10	Dayton	128	97.5	91.5	32.9	93.9	69.5	72.0
10	Mansfield	38	95.8	100.0	8.7	100.0	56.5	79.2
10	Youngstown	44	100.0	100.0	25.6	82.1	87.2	43.6
11	Ann Arbor	54	100.0	100.0	63.0	82.6	97.8	56.5
11	Battle Creek	78	100.0	98.5	61.2	94.0	97.0	74.6
11	Danville	42	100.0	97.1	<u>94.1</u>	64.7	84.8	67.6
11	Detroit	88	100.0	97.4	5.1	74.4	53.8	67.9
11	Northern Indiana	84	98.7	98.7	<u>79.5</u>	96.2	74.4	66.2
12	Chicago-West Side	73	93.3	100.0	<u>97.8</u>	97.8	23.9	60.9
12	Madison	50	100.0	100.0	34.8	97.8	77.8	71.7

VISN	SITE	FOLLOW- UP VETS #	SUPPORTIVE CONTACT %	ACTIVE MONITOR %	REHABIL- ITATION %	PSYCHOTHER. RELATIONSHIP %	SOCIAL/REC. ACTIVITIES %	CRISIS INTERVENT %
12	Milwaukee	53	100.0	100.0	61.1	100.0	88.9	80.6
12	North Chicago	135	97.3	96.4	47.3	76.4	75.5	47.3
12	Tomah	52	95.5	88.6	47.7	67.4	77.3	54.5
15	St. Louis	67	100.0	96.3	22.2	83.3	85.2	75.9
15	Topeka	104	98.9	100.0	43.8	73.0	82.0	80.9
16	Gulf Coast	53	97.4	97.4	33.3	97.4	61.5	71.8
16	Houston	69	96.7	98.4	32.8	86.9	44.3	80.3
16	Little Rock	58	97.1	97.1	42.9	94.1	94.3	82.9
16	New Orleans	60	97.7	100.0	<u>85.7</u>	100.0	86.0	86.0
17	Dallas	81	91.8	86.3	46.6	78.1	20.5	67.1
17	San Antonio	38	100.0	100.0	66.7	100.0	93.5	96.8
17	Temple (Waco)	73	100.0	100.0	0.0	100.0	57.1	45.7
18	Albuquerque	73	96.9	95.4	<u>78.5</u>	89.2	84.6	95.4
18	Phoenix	103	94.7	89.7	10.5	40.4	71.9	38.6
19	Denver	77	97.0	97.0	59.7	97.0	68.7	68.7
19	Fort Harrison	51	90.9	93.2	13.6	34.1	38.6	34.1
19	Grand Junction	45	97.6	92.7	53.7	92.7	68.3	70.7
19	Salt Lake City	71	100.0	98.1	42.3	75.0	69.2	86.5
19	Sheridan	18	100.0	100.0	57.1	100.0	21.4	71.4
19	Southern Colorado	93	97.8	97.8	52.2	73.9	78.3	91.3
20	American Lake	54	98.0	100.0	<u>95.9</u>	93.9	93.9	61.2
20	Boise	40	96.4	96.4	50.0	85.7	67.9	64.3
20	Portland	80	97.0	98.5	69.2	53.0	40.9	65.2
20	Seattle	63	97.1	94.1	41.2	58.8	79.4	82.4
21	Palo Alto	73	97.6	97.7	<u>95.3</u>	100.0	90.7	74.4
21	San Francisco	46	100.0	100.0	<u>92.1</u>	89.5	47.4	81.6
22	Greater Los Angeles	69	91.1	97.7	53.3	71.1	88.9	91.1
22	Long Beach	49	100.0	96.6	<u>89.7</u>	82.8	82.8	58.6
22	San Diego	76	98.0	96.0	66.0	88.0	86.0	85.7
23	Iowa City	52	100.0	95.8	43.8	72.3	29.2	70.8
23	Knoxville	90	98.7	100.0	48.1	85.7	66.2	74.0
23	Minneapolis	72	98.5	89.2	49.2	89.2	32.3	63.1
23	Omaha	48	97.4	97.4	<u>94.7</u>	89.5	86.8	52.6
23	St.Cloud	40	100.0	100.0	58.1	100.0	35.5	48.4
ALL SITES		5696	97.3	96.6	50.1	84.6	65.2	68.0
SITE AVERAGE		67.8	97.6	96.8	50.7	85.5	66.5	69.4
SITE STD. DEV.		29.4	2.9	3.4	23.8	14.9	23.4	16.9

Shaded values do not meet the threshold level (25%) for the minimum standard. Bold/Underlined values represent positive outliers.

Source: Client Interview

TABLE 2-15B. THERAPEUTIC SERVICES

VISN	SITE	FOLLOW- UP VETS #	MEDICATN MGMT %	MEDICAL SCREEN %	SEEN FOR SUB. ABUSE %	HOUSING SUPPORT %	VOCATION SUPPORT %
1	Bedford	142	85.6	80.0	55.6	62.2	33.3
1	Brockton	80	70.0	54.3	17.1	35.7	11.4
1	Togus	35	96.8	96.8	12.9	25.8	0.0
1	West Haven	67	78.9	68.4	35.1	63.2	31.6
2	Albany	54	87.5	72.9	45.8	62.5	29.2
2	Buffalo	92	47.1	31.4	26.1	41.4	8.7
2	Canandaigua	105	73.7	79.8	25.3	38.9	14.7
2	Syracuse	51	60.5	39.5	15.8	47.4	23.7
3	Brooklyn	60	67.5	42.5	10.0	32.5	12.5
3	Hudson Valley	90	89.4	87.1	4.7	3.6	2.4
3	New Jersey	95	90.1	66.7	28.4	51.9	12.3
3	Northport	114	58.6	59.6	22.2	59.6	17.2
4	Coatesville	109	75.7	82.4	32.4	68.9	17.6
4	Lebanon	20	70.0	63.6	40.0	36.4	36.4
4	Philadelphia	32	100.0	73.3	40.0	53.3	33.3
4	Pittsburgh	132	86.0	34.6	15.9	12.1	7.5
5	Baltimore	28	80.0	93.3	33.3	40.0	33.3
5	Martinsburg	49	32.3	87.1	41.9	26.7	32.3
5	Perry Point	71	94.0	71.6	37.3	94.0	43.9
5	Washington, DC	49	100.0	68.4	21.1	57.9	42.1
6	Fayetteville	36	69.0	66.7	20.7	31.0	3.4
6	Hampton	63	86.3	86.3	66.7	66.7	27.5
6	Salem	38	25.0	87.5	68.8	71.9	9.4
6	Salisbury	61	95.2	95.2	14.3	85.7	23.8
7	Atlanta	69	97.4	76.3	2.6	13.2	2.6
7	Augusta	78	83.1	81.7	40.8	69.0	43.7
7	Birmingham	39	100.0	100.0	32.0	48.0	4.2
7	Charleston	35	100.0	92.3	61.5	61.5	30.8
7	Columbia	57	100.0	75.0	18.8	46.9	6.3
7	Tuscaloosa	74	92.3	100.0	9.6	59.6	21.2
7	Tuskegee	61	77.5	72.5	47.5	40.0	32.5
8	Gainesville	57	94.5	83.6	18.2	49.1	10.9
8	Miami	89	91.8	89.8	4.1	22.4	28.6
8	Tampa	55	48.8	56.1	9.8	53.7	7.3
8	West Palm Beach	25	93.3	60.0	20.0	46.7	26.7
10	Akron	44	80.0	77.1	31.4	22.9	20.0
10	Chillicothe	113	76.4	61.1	15.3	50.0	20.8
10	Cincinnati	147	84.7	71.4	43.9	66.3	17.3
10	Cleveland	146	66.0	64.2	17.9	34.0	10.4
10	Columbus	29	61.9	81.0	9.5	23.8	23.8
10	Dayton	128	64.6	61.0	17.1	34.1	14.6
10	Mansfield	38	50.0	82.6	16.7	58.3	20.8
10	Youngstown	44	94.9	87.2	23.1	33.3	5.1
11	Ann Arbor	54	100.0	89.1	32.6	87.0	37.0
11	Battle Creek	78	70.1	71.2	52.2	80.6	54.5
11	Danville	42	90.9	76.5	61.8	32.4	8.8
11	Detroit	88	97.4	94.9	12.8	33.8	2.6
11	Northern Indiana	84	93.6	70.5	28.2	62.8	21.8
12	Chicago-West Side	73	97.8	82.6	37.0	26.1	6.5

VISN	SITE	FOLLOW- UP VETS #	MEDICATN MGMT %	MEDICAL SCREEN %	SEEN FOR SUB. ABUSE %	HOUSING SUPPORT %	VOCATION SUPPORT %
12	Madison	50	100.0	91.3	43.5	58.7	19.6
12	Milwaukee	53	83.3	94.4	69.4	66.7	41.7
12	North Chicago	135	65.5	60.6	21.8	68.2	20.9
12	Tomah	52	86.4	93.2	38.6	52.3	31.8
15	St. Louis	67	68.5	72.2	44.4	44.4	18.5
15	Topeka	104	97.7	94.4	33.0	83.1	23.6
16	Gulf Coast	53	64.1	56.4	17.9	33.3	7.7
16	Houston	69	95.1	91.8	23.0	36.1	6.6
16	Little Rock	58	88.2	85.7	37.1	54.3	5.7
16	New Orleans	60	100.0	76.7	44.2	55.8	65.1
17	Dallas	81	95.9	74.0	24.7	39.7	8.2
17	San Antonio	38	100.0	83.9	25.8	74.2	25.8
17	Temple (Waco)	73	88.6	20.0	0.0	57.1	2.9
18	Albuquerque	73	93.8	86.2	64.6	69.2	61.5
18	Phoenix	103	68.4	86.0	26.3	21.1	0.0
19	Denver	77	85.1	70.1	20.9	40.3	13.4
19	Fort Harrison	51	54.5	34.1	4.5	40.9	9.1
19	Grand Junction	45	70.7	82.9	36.6	26.8	2.4
19	Salt Lake City	71	92.3	88.5	26.9	67.3	25.0
19	Sheridan	18	85.7	92.9	57.1	7.1	7.1
19	Southern Colorado	93	80.4	82.6	37.8	58.7	39.1
20	American Lake	54	89.8	71.4	22.4	46.9	2.0
20	Boise	40	78.6	60.7	14.3	32.1	0.0
20	Portland	80	84.8	84.6	21.2	63.6	3.0
20	Seattle	63	94.1	85.3	29.4	79.4	8.8
21	Palo Alto	73	86.0	81.4	51.2	88.4	34.9
21	San Francisco	46	100.0	92.1	31.6	52.6	10.5
22	Greater Los Angeles	69	88.9	82.2	22.2	68.9	22.2
22	Long Beach	49	89.7	89.7	35.7	44.8	27.6
22	San Diego	76	82.0	82.0	68.0	68.0	46.0
23	Iowa City	52	75.0	72.9	18.8	27.1	22.9
23	Knoxville	90	85.7	89.6	54.5	48.7	14.3
23	Minneapolis	72	86.2	56.9	27.7	67.7	24.6
23	Omaha	48	89.5	92.1	31.6	23.7	23.7
23	St.Cloud	40	38.7	77.4	19.4	45.2	32.3
ALL SITES		5696	81.3	74.4	29.6	50.1	19.6
SITE AVERAGE		67.8	81.7	76.0	30.3	49.3	20.2
SITE STD. DEV.		29.4	16.6	16.5	16.8	19.7	14.5

Source: Client Interview

TABLE 2-16. CLIENT RATED THERAPEUTIC ALLIANCE

6 Month Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2+4)	4 Change at Follow-up	5 Percent Change (4/2)
1	Bedford	103	37.16	44.58	7.42	20.0%
1	Brockton	38	38.04	45.71	7.67	20.2%
1	Togus	31	35.17	40.68	5.51	15.7%
1	West Haven	32	34.86	37.70	2.84	8.1%
2	Albany	26	40.31	46.68	6.37	15.8%
2	Buffalo	55	40.07	44.42	4.35	10.8%
2	Canandaigua	56	33.95	35.01	1.06	3.1%
2	Syracuse	33	36.16	41.22	5.07	14.0%
3	Brooklyn	40	36.12	39.71	3.58	9.9%
3	Hudson Valley	42	33.92	32.42	-1.50	-4.4%
3	New Jersey	62	34.01	34.26	0.25	0.7%
3	Northport	30	30.23	36.34	6.11	20.2%
4	Coatesville	87	35.28	39.83	4.56	12.9%
4	Lebanon	17	34.47	40.66	6.19	17.9%
4	Philadelphia	31	40.16	48.22	8.06	20.1%
4	Pittsburgh	118	36.76	41.14	4.37	11.9%
5	Baltimore	24	35.19	37.42	2.23	6.3%
5	Martinsburg	45	37.13	45.05	7.92	21.3%
5	Perry Point	47	36.56	39.60	3.03	8.3%
5	Washington, DC	36	37.64	43.80	6.16	16.4%
6	Fayetteville	27	35.67	42.63	6.96	19.5%
6	Hampton	36	36.19	45.31	9.12	25.2%
6	Salem	31	37.87	43.11	5.24	13.8%
6	Salisbury	36	36.21	37.89	1.68	4.6%
7	Atlanta	45	35.81	38.71	2.90	8.1%
7	Augusta	75	36.15	36.59	0.44	1.2%
7	Birmingham	24	32.46	35.62	3.16	9.7%
7	Charleston	29	36.50	40.85	4.34	11.9%
7	Columbia	35	37.77	45.66	7.90	20.9%
7	Tuscaloosa	35	40.04	44.48	4.44	11.1%
7	Tuskegee	47	33.49	39.16	5.67	16.9%
8	Gainesville	43	33.23	34.21	0.98	2.9%
8	Miami	39	36.94	43.57	6.63	17.9%
8	Tampa	15	38.73	40.28	1.54	4.0%
8	West Palm Beach	22	40.67	47.65	6.98	17.2%
10	Akron	34	36.96	40.32	3.36	9.1%
10	Chillicothe	66	38.33	45.62	7.29	19.0%
10	Cincinnati	120	39.37	43.60	4.23	10.7%
10	Cleveland	100	36.74	40.26	3.53	9.6%
10	Columbus	26	37.62	43.71	6.08	16.2%
10	Dayton	100	35.49	41.60	6.11	17.2%
10	Mansfield	31	34.51	36.79	2.28	6.6%
10	Youngstown	27	39.76	46.64	6.88	17.3%
11	Ann Arbor	36	36.47	39.61	3.14	8.6%
11	Battle Creek	50	37.56	42.34	4.78	12.7%
11	Danville	23	36.86	44.06	7.20	19.5%
11	Detroit	47	32.91	34.30	1.40	4.2%
11	Northern Indiana	38	34.49	36.69	2.20	6.4%
12	Chicago-West Side	47	38.45	43.13	4.68	12.2%
12	Madison	46	36.59	39.99	3.40	9.3%
12	Milwaukee	49	33.91	41.12	7.20	21.2%

TABLE 2-16. CLIENT RATED THERAPEUTIC ALLIANCE

6 Month Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2+4)	4 Change at Follow-up	5 Percent Change (4/2)
12	North Chicago	107	35.92	39.03	3.10	8.6%
12	Tomah	23	37.77	42.28	4.51	11.9%
15	St. Louis	51	30.85	37.63	6.78	22.0%
15	Topeka	31	34.49	35.15	0.66	1.9%
16	Gulf Coast	38	35.10	42.53	7.43	21.2%
16	Houston	54	36.40	40.81	4.42	12.1%
16	Little Rock	43	36.84	40.90	4.06	11.0%
16	New Orleans	19	34.68	40.00	5.31	15.3%
17	Dallas	71	36.35	39.35	3.00	8.3%
17	San Antonio	22	30.71	36.56	5.85	19.1%
17	Temple (Waco)	69	38.42	37.64	-0.78	-2.0%
18	Albuquerque	59	39.82	40.67	0.85	2.1%
18	Phoenix	52	36.50	38.74	2.24	6.1%
19	Denver	64	38.19	44.63	6.45	16.9%
19	Fort Harrison	39	37.74	40.59	2.85	7.5%
19	Grand Junction	41	36.99	40.60	3.62	9.8%
19	Salt Lake City	59	37.95	43.28	5.33	14.1%
19	Sheridan	18	37.54	36.67	-0.86	-2.3%
19	Southern Colorado	76	34.45	37.77	3.32	9.7%
20	American Lake	35	33.43	35.84	2.41	7.2%
20	Boise	36	36.05	40.88	4.83	13.4%
20	Portland	31	36.79	40.02	3.23	8.8%
20	Seattle	44	38.12	38.73	0.61	1.6%
21	Palo Alto	59	31.67	35.27	3.60	11.4%
21	San Francisco	36	35.08	37.41	2.33	6.6%
22	Greater Los Angeles	51	36.45	39.90	3.44	9.4%
22	Long Beach	39	36.24	41.82	5.59	15.4%
22	San Diego	48	36.46	42.90	6.44	17.7%
23	Iowa City	44	36.92	43.66	6.73	18.2%
23	Knoxville	79	36.07	42.45	6.38	17.7%
23	Minneapolis	61	33.35	35.94	2.59	7.8%
23	Omaha	32	37.06	44.39	7.33	19.8%
23	St.Cloud	34	37.49	40.81	3.32	8.9%
ALL SITES		3897	36.29	40.57	4.29	11.81%
SITE AVERAGE		46.39	36.25	40.53	4.29	11.80%
SITE STD. DEV.		22.86	2.19	3.48	2.36	6.47%

Change values are least squares means derived from analysis of covariance including site,time,
baseline value, and eleven other baseline covariates

Shaded values represent reductions in alliance at follow-up

Bold/Underlined values represent adjusted positive outliers

Source: Client Interview

TABLE 2-17. FIDELITY TO ASSERTIVE COMMUNITY TREATMENT MODEL.

VISN	SITE	HUMAN RESOURCES	ORGANIZ'L BOUNDARIES	SERVICES	SUB. ABUSE TX	TOTAL SCORE	AVG SCORE
1	Bedford	3.7	4.3	3.3	3.7	83.0	3.80
1	Brockton	4.7	4.4	4.0	3.0	92.0	4.20
1	Togus	4.7	4.6	4.2	2.3	92.0	4.20
1	West Haven	4.0	4.9	4.7	4.0	98.0	<u>4.50</u>
2	Albany	3.8	4.3	3.7	4.0	87.0	4.00
2	Buffalo	3.5	4.0	3.8	2.3	79.0	3.60
2	Canandaigua	3.8	4.3	3.7	3.3	85.0	3.90
2	Syracuse	3.5	4.4	2.7	2.7	76.0	3.50
3	Brooklyn	3.5	4.4	3.2	2.7	79.0	3.60
3	Hudson Valley	4.5	4.5	3.8	2.3	84.0	3.80
3	New Jersey	3.8	4.1	4.2	4.3	90.0	4.10
3	Northport	2.8	4.9	3.8	2.7	82.0	3.70
4	Coatesville	3.5	4.7	3.2	2.7	81.0	3.70
4	Lebanon	4.7	3.9	4.5	3.3	92.0	4.20
4	Philadelphia	4.0	4.7	4.0	4.7	95.0	<u>4.30</u>
4	Pittsburgh	4.3	4.7	4.0	2.3	90.0	4.10
5	Baltimore	3.7	4.9	4.7	3.3	94.0	<u>4.30</u>
5	Martinsburg	4.5	4.1	3.3	5.0	91.0	4.10
5	Perry Point	3.8	4.6	4.7	4.7	97.0	<u>4.40</u>
5	Washington, DC	3.3	3.9	3.7	4.3	82.0	3.70
6	Fayetteville	4.2	4.4	3.2	2.7	83.0	3.80
6	Hampton	3.8	4.6	4.3	4.3	94.0	<u>4.30</u>
6	Salem	4.5	4.4	3.8	2.3	88.0	4.00
6	Salisbury	4.0	3.1	4.0	3.0	79.0	3.60
7	Atlanta	4.3	4.6	3.2	1.7	82.0	3.70
7	Augusta	3.7	4.7	4.5	5.0	97.0	<u>4.40</u>
7	Birmingham	4.5	4.1	3.5	4.7	91.0	4.10
7	Charleston	3.0	4.3	4.2	2.3	80.0	3.60
7	Columbia	4.3	3.9	3.5	3.0	83.0	3.80
7	Tuscaloosa	4.7	5.0	4.5	3.0	99.0	<u>4.50</u>
7	Tuskegee	3.8	4.9	3.8	2.0	86.0	3.90
8	Gainesville	4.5	4.0	4.3	2.3	88.0	4.00
8	Miami	3.3	4.1	4.5	2.0	82.0	3.70
8	Tampa	4.8	3.9	4.3	1.7	87.0	4.00
8	West Palm Beach	4.0	3.7	3.8	1.7	78.0	3.60
10	Akron	4.5	4.9	3.8	3.0	93.0	4.20
10	Chillicothe	4.2	4.3	4.2	2.7	88.0	4.00
10	Cincinnati	4.0	4.3	4.3	3.7	91.0	4.10
10	Cleveland	4.3	4.7	3.7	2.7	89.0	4.10
10	Columbus	2.3	3.6	3.0	3.0	66.0	3.00
10	Dayton	4.2	3.7	4.2	2.7	84.0	3.80
10	Mansfield	4.3	4.4	3.7	3.0	88.0	4.00
10	Youngstown	3.7	5.0	4.0	3.0	90.0	4.10
11	Ann Arbor	4.7	4.9	4.2	4.3	100.0	<u>4.60</u>
11	Battle Creek	3.3	4.9	4.0	2.3	85.0	3.90
11	Danville	4.7	4.4	3.5	1.7	85.0	3.90
11	Detroit	3.8	3.9	2.8	2.0	73.0	3.30
11	Northern Indiana	4.0	4.7	4.2	2.0	88.0	4.00
12	Chicago-West Side	4.3	4.1	4.0	3.0	88.0	4.00

VISN	SITE	HUMAN RESOURCES	ORGANIZ'L BOUNDARIES	SERVICES	SUB. ABUSE TX	TOTAL SCORE	AVG SCORE
12	Madison	4.7	4.7	4.2	5.0	101.0	<u>4.60</u>
12	Milwaukee	4.7	3.3	4.0	3.7	86.0	3.90
12	North Chicago	3.7	4.0	3.5	2.3	78.0	3.60
12	Tomah	4.3	4.3	3.7	3.3	88.0	4.00
15	St. Louis	4.2	3.6	3.7	1.7	77.0	3.50
15	Topeka	4.7	4.9	4.0	3.7	97.0	<u>4.40</u>
16	Gulf Coast	3.8	4.1	3.3	2.7	80.0	3.60
16	Houston	4.0	4.9	4.0	1.3	86.0	3.90
16	Little Rock	4.5	4.6	4.3	3.7	96.0	<u>4.40</u>
16	New Orleans	4.7	5.0	3.5	3.7	95.0	<u>4.30</u>
17	Dallas	3.5	4.4	3.8	2.7	83.0	3.80
17	San Antonio	4.2	4.1	4.5	2.0	87.0	4.00
17	Temple (Waco)	4.3	3.9	3.2	3.3	82.0	3.70
18	Albuquerque	4.7	4.4	4.2	3.0	93.0	4.20
18	Phoenix	4.2	4.4	4.0	3.0	89.0	4.10
19	Denver	4.2	4.9	4.0	3.0	92.0	4.20
19	Fort Harrison	3.7	4.1	3.7	2.0	79.0	3.60
19	Grand Junction	4.0	4.4	3.8	4.7	92.0	4.20
19	Salt Lake City	3.3	4.3	3.8	3.3	83.0	3.80
19	Sheridan	3.0	4.4	3.7	2.7	79.0	3.60
19	Southern Colorado	3.8	4.1	3.7	1.0	77.0	3.50
20	American Lake	4.3	4.7	4.2	2.7	92.0	4.20
20	Boise	4.3	4.7	4.2	3.7	95.0	<u>4.30</u>
20	Portland	4.2	4.4	4.0	2.7	88.0	4.00
20	Seattle	4.2	4.4	3.2	3.7	86.0	3.90
21	Palo Alto	3.3	4.1	4.7	2.3	84.0	3.80
21	San Francisco	4.3	4.4	3.7	3.0	88.0	4.00
22	Greater Los Angeles	3.3	4.7	3.8	2.3	83.0	3.80
22	Long Beach	4.2	4.4	3.7	3.0	87.0	4.00
22	San Diego	4.5	4.6	3.8	3.0	91.0	4.10
23	Iowa City	3.8	4.6	4.3	2.7	89.0	4.10
23	Knoxville	4.3	4.1	3.7	2.3	84.0	3.80
23	Minneapolis	4.2	4.6	4.3	2.7	91.0	4.10
23	Omaha	4.5	3.7	3.5	1.7	79.0	3.60
23	St.Cloud	3.0	4.3	3.5	3.3	79.0	3.60
SITE AVERAGE		4.0	4.4	3.9	3.0	86.8	4.0
SITE STD. DEV.		0.5	0.4	0.4	0.9	6.6	0.30

Source: Assertive Community Treatment Fidelity Scale from the FY 2005 Annual Progress Report.
Total score range: 22-110

Shaded values exceed one standard deviation from the mean in undesired direction.

TABLE 2-18. VA HOSPITAL USE 183 DAYS PRE -vs- POST-ENTRY PTF FY05

VISN SITE	Total N FY05	1 N 183 Days	2 Pre-IDF MH Days/ Veteran	3 Post-IDF MH Days/ Veteran	4 Change MH Days/ Veteran (col.3-2)	5 % Change MH Days (4/2)	6 Change MH Cost*/ Inp't Veteran (4x\$852)
1 Bedford	142	136	38.3	22.2	-16.1	-42.1%	(\$13,739)
1 Brockton	80	61	74.7	12.1	-62.6	<u>-83.7%</u>	(\$53,327)
1 Togus	35	28	51.0	20.4	-30.6	-60.1%	(\$26,077)
1 West Haven	67	38	64.2	22.1	-42.2	-65.7%	(\$35,941)
2 Albany	54	38	30.9	7.2	-23.8	-76.8%	(\$20,246)
2 Buffalo	92	80	17.7	9.2	-8.5	-48.0%	(\$7,231)
2 Canandaigua	105	77	66.6	4.3	-62.3	<u>-93.5%</u>	(\$53,045)
2 Syracuse	51	38	28.2	11.0	-17.2	-61.0%	(\$14,641)
3 Brooklyn	60	55	48.8	11.3	-37.5	-76.8%	(\$31,911)
3 Hudson Valley	90	70	133.2	23.3	-109.9	<u>-82.5%</u>	(\$93,659)
3 New Jersey	95	90	32.2	10.8	-21.3	-66.3%	(\$18,157)
3 Northport	114	108	40.4	19.3	-21.1	-52.3%	(\$17,971)
4 Coatesville	109	95	65.3	13.1	-52.3	-80.0%	(\$44,528)
4 Lebanon	20	15	37.9	8.0	-29.9	-78.9%	(\$25,446)
4 Philadelphia	32	18	47.7	8.3	-39.4	<u>-82.5%</u>	(\$33,559)
4 Pittsburgh	132	124	51.7	10.0	-41.7	-80.6%	(\$35,509)
5 Baltimore	28	21	65.0	12.9	-52.2	-80.2%	(\$44,466)
5 Martinsburg	49	35	24.1	12.1	-12.1	-50.0%	(\$10,273)
5 Perry Point	71	69	126.6	12.3	-114.3	<u>-90.3%</u>	(\$97,363)
5 Washington, DC	49	23	20.2	8.7	-11.5	-56.8%	(\$9,779)
6 Fayetteville	36	32	22.2	7.3	-14.8	-66.9%	(\$12,620)
6 Hampton	63	54	31.8	9.0	-22.9	-71.8%	(\$19,470)
6 Salem	38	37	27.6	9.3	-18.3	-66.3%	(\$15,612)
6 Salisbury	61	38	80.1	27.5	-52.7	-65.7%	(\$44,865)
7 Atlanta	69	53	25.9	3.1	-22.8	<u>-88.1%</u>	(\$19,467)
7 Augusta	78	73	115.9	13.4	-102.5	<u>-88.4%</u>	(\$87,301)
7 Birmingham	39	33	65.0	11.6	-53.5	-82.2%	(\$45,543)
7 Charleston	35	29	31.3	9.8	-21.5	-68.8%	(\$18,333)
7 Columbia	57	42	19.1	5.5	-13.6	-71.0%	(\$11,563)
7 Tuscaloosa	74	65	75.0	9.4	-65.7	<u>-87.5%</u>	(\$55,944)
7 Tuskegee	61	53	35.0	16.6	-18.4	-52.6%	(\$15,674)
8 Gainesville	57	56	32.4	5.8	-26.6	-82.1%	(\$22,700)
8 Miami	89	71	29.7	15.2	-14.5	-48.8%	(\$12,360)
8 Tampa	55	47	23.3	11.0	-12.3	-52.8%	(\$10,478)
8 West Palm Beach	25	15	17.9	7.5	-10.3	-57.8%	(\$8,804)
10 Akron	44	40	26.4	15.8	-10.5	-39.9%	(\$8,967)
10 Chillicothe	113	88	30.4	14.5	-15.9	-52.3%	(\$13,545)
10 Cincinnati	147	123	20.0	6.9	-13.1	-65.5%	(\$11,166)
10 Cleveland	146	132	35.3	11.2	-24.1	-68.3%	(\$20,525)
10 Columbus	29	25	17.9	7.6	-10.2	-57.3%	(\$8,724)
10 Dayton	128	117	6.9	4.5	-2.5	-35.6%	(\$2,097)
10 Mansfield	38	35	21.4	10.5	-10.9	-51.1%	(\$9,299)
10 Youngstown	44	43	12.0	1.3	-10.7	<u>-89.2%</u>	(\$9,134)
11 Ann Arbor	54	54	33.4	8.2	-25.2	-75.5%	(\$21,474)
11 Battle Creek	78	73	73.3	18.5	-54.8	-74.8%	(\$46,720)
11 Danville	42	37	22.7	8.4	-14.3	-63.1%	(\$12,181)
11 Detroit	88	85	38.0	15.6	-22.4	-59.1%	(\$19,125)
11 Northern Indiana	84	80	47.8	10.9	-36.8	-77.1%	(\$31,386)
12 Chicago-West Side	73	70	42.5	10.9	-31.6	-74.4%	(\$26,923)
12 Madison	50	50	23.7	5.2	-18.5	-77.9%	(\$15,728)
12 Milwaukee	53	40	6.9	1.9	-5.0	-72.3%	(\$4,217)

VISN SITE	Total N FY05	1 N 183 Days	2 Pre-IDF MH Days/ Veteran	3 Post-IDF MH Days/ Veteran	4 Change MH Days/ Veteran (col.3-2)	5 % Change MH Days (4/2)	6 Change MH Cost*/ Inp't Veteran (4x\$852)
12 North Chicago	135	125	53.2	8.4	-44.8	<u>-84.2%</u>	(\$38,163)
12 Tomah	52	49	7.1	0.7	-6.4	<u>-89.7%</u>	(\$5,425)
15 St. Louis	67	58	24.1	9.2	-14.9	-61.7%	(\$12,677)
15 Topeka	104	100	40.5	20.1	-20.4	-50.4%	(\$17,381)
16 Gulf Coast	53	48	49.6	13.9	-35.7	-72.0%	(\$30,424)
16 Houston	69	66	25.2	9.9	-15.3	-60.7%	(\$13,025)
16 Little Rock	58	50	44.9	28.0	-16.9	-37.7%	(\$14,416)
16 New Orleans	60	55	27.1	7.4	-19.6	-72.5%	(\$16,730)
17 Dallas	81	75	38.6	11.8	-26.8	-69.4%	(\$22,845)
17 San Antonio	38	33	35.3	10.2	-25.1	-71.0%	(\$21,352)
17 Temple (Waco)	73	54	52.9	7.6	-45.2	<u>-85.6%</u>	(\$38,545)
18 Albuquerque	73	69	30.2	13.2	-17.0	-56.4%	(\$14,521)
18 Phoenix	103	92	18.4	9.4	-9.0	-49.1%	(\$7,696)
19 Denver	77	76	47.4	12.6	-34.8	-73.3%	(\$29,607)
19 Fort Harrison	51	47	21.9	1.4	-20.5	<u>-93.7%</u>	(\$17,475)
19 Grand Junction	45	43	20.8	9.0	-11.8	-56.8%	(\$10,065)
19 Salt Lake City	71	62	17.7	10.5	-7.2	-40.7%	(\$6,143)
19 Sheridan	18	16	57.8	12.5	-45.3	-78.4%	(\$38,553)
19 Southern Colorado	93	87	9.2	3.3	-5.9	-64.0%	(\$5,004)
20 American Lake	54	51	67.9	11.8	-56.1	<u>-82.6%</u>	(\$47,812)
20 Boise	40	40	14.0	8.6	-5.4	-38.8%	(\$4,622)
20 Portland	80	73	39.7	13.0	-26.7	-67.3%	(\$22,747)
20 Seattle	63	54	13.0	4.2	-8.8	-67.6%	(\$7,479)
21 Palo Alto	73	48	34.5	13.5	-21.0	-60.9%	(\$17,910)
21 San Francisco	46	42	42.5	9.2	-33.3	-78.3%	(\$28,359)
22 Greater Los Angeles	69	58	57.9	25.7	-32.2	-55.6%	(\$27,426)
22 Long Beach	49	32	39.0	13.9	-25.1	-64.3%	(\$21,353)
22 San Diego	76	56	35.5	8.1	-27.4	-77.1%	(\$23,308)
23 Iowa City	52	49	26.2	9.5	-16.7	-63.7%	(\$14,206)
23 Knoxville	90	83	18.9	4.1	-14.8	-78.3%	(\$12,626)
23 Minneapolis	72	67	63.0	5.6	-57.4	<u>-91.1%</u>	(\$48,895)
23 Omaha	48	41	15.8	3.9	-11.9	-75.2%	(\$10,141)
23 St.Cloud	40	40	24.8	11.0	-13.8	-55.6%	(\$11,715)
ALL SITES	5696	4948	40.0	11.2	-28.8	-72.1%	(\$24,556)
SITE AVERAGE	68	59	38.9	10.9	-28.0	-68.0%	(\$23,898)
SITE STD. DEV.	29	28	24.2	5.6	21.9	14.4%	\$18,660

FY 2005 National general psychiatry per diem = \$852 (NMHPPMS). Unit cost estimates changed this year due to a shift in VHA accounting from the CDR to the Decision Support System

Total N FY05=IDF3 Table <10/01/05 (including terminated clients)

Shaded values exceed one standard deviation from the mean in undesired direction. Bold /Underlined values represent positive outliers.

Source: VA automated Patient Treatment File FY05; NMHPPMS FY05

TABLE 2-18a. VA HOSPITAL USE 365 DAYS PRE -vs- POST-ENTRY PTF FY05

VISN	SITE	Total N FY05	1 N 365 Days	2 Pre-IDF MH Days/ Veteran	3 Post-IDF MH Days/ Veteran	4 Change MH Days/ Veteran (col 3-2)	5 % Change MH Days/ (4/2)	6 Change MH Cost*/ Inp't Veteran (4x\$852)
1	Bedford	142	123	57.1	34.0	-23.1	-40.5%	(\$19,721)
1	Brockton	80	55	144.3	23.6	-120.7	-83.7%	(\$102,860)
1	Togus	35	26	79.2	26.8	-52.4	-66.2%	(\$44,664)
1	West Haven	67	31	96.7	33.3	-63.4	-65.5%	(\$54,006)
2	Albany	54	36	43.0	9.4	-33.7	-78.2%	(\$28,684)
2	Buffalo	92	77	23.3	18.1	-5.2	-22.4%	(\$4,448)
2	Canandaigua	105	74	123.7	10.1	-113.6	-91.8%	(\$96,771)
2	Syracuse	51	35	36.5	18.8	-17.7	-48.4%	(\$15,044)
3	Brooklyn	60	49	68.0	25.2	-42.9	-63.0%	(\$36,532)
3	Hudson Valley	90	69	242.4	47.8	-194.6	-80.3%	(\$165,770)
3	New Jersey	95	82	57.8	22.4	-35.5	-61.3%	(\$30,204)
3	Northport	114	96	66.4	31.2	-35.2	-53.0%	(\$29,989)
4	Coatesville	109	85	106.5	23.4	-83.1	-78.0%	(\$70,776)
4	Pittsburgh	132	119	75.6	18.1	-57.5	-76.1%	(\$49,008)
5	Baltimore	28	19	80.8	29.9	-50.8	-62.9%	(\$43,317)
5	Martinsburg	49	26	31.3	18.1	-13.2	-42.1%	(\$11,240)
5	Perry Point	71	68	215.4	22.5	-193.0	-89.6%	(\$164,411)
5	Washington, DC	49	20	31.3	11.6	-19.8	-63.1%	(\$16,827)
6	Fayetteville	36	26	44.2	10.5	-33.7	-76.2%	(\$28,706)
6	Hampton	63	51	54.3	14.3	-40.1	-73.8%	(\$34,130)
6	Salem	38	34	46.8	24.2	-22.6	-48.2%	(\$19,220)
6	Salisbury	61	38	130.2	52.8	-77.4	-59.5%	(\$65,940)
7	Atlanta	69	45	34.8	5.4	-29.3	-84.3%	(\$24,973)
7	Augusta	78	70	191.2	20.0	-171.3	-89.6%	(\$145,935)
7	Birmingham	39	25	114.3	35.0	-79.3	-69.4%	(\$67,581)
7	Charleston	35	21	55.9	15.8	-40.1	-71.8%	(\$34,161)
7	Columbia	57	20	37.0	16.0	-21.0	-56.7%	(\$17,849)
7	Tuscaloosa	74	61	123.2	17.4	-105.9	-85.9%	(\$90,186)
7	Tuskegee	61	50	52.9	26.1	-26.8	-50.6%	(\$22,817)
8	Gainesville	57	56	50.1	12.8	-37.3	-74.5%	(\$31,813)
8	Miami	89	54	53.2	27.7	-25.5	-48.0%	(\$21,742)
8	Tampa	55	41	38.0	18.5	-19.5	-51.3%	(\$16,624)
10	Akron	44	31	40.1	25.1	-15.0	-37.4%	(\$12,753)
10	Chillicothe	113	70	63.5	28.9	-34.6	-54.5%	(\$29,455)
10	Cincinnati	147	109	28.5	14.7	-13.8	-48.4%	(\$11,740)
10	Cleveland	146	115	58.2	20.7	-37.4	-64.3%	(\$31,894)
10	Columbus	29	23	29.5	10.8	-18.7	-63.3%	(\$15,929)
10	Dayton	128	101	11.5	8.3	-3.1	-27.4%	(\$2,683)
10	Mansfield	38	26	44.7	16.8	-27.9	-62.4%	(\$23,790)
10	Youngstown	44	36	19.1	5.7	-13.3	-70.0%	(\$11,360)
11	Ann Arbor	54	52	52.1	17.7	-34.4	-66.0%	(\$29,296)
11	Battle Creek	78	65	120.0	44.0	-76.0	-63.3%	(\$64,739)
11	Danville	42	28	24.7	16.3	-8.4	-34.1%	(\$7,181)
11	Detroit	88	79	48.9	20.1	-28.9	-59.0%	(\$24,600)
11	Northern Indiana	84	74	84.2	20.5	-63.7	-75.6%	(\$54,275)
12	Chicago-West Side	73	66	62.6	19.6	-43.0	-68.7%	(\$36,662)
12	Madison	50	47	39.5	7.4	-32.1	-81.3%	(\$27,373)
12	Milwaukee	53	25	15.5	4.1	-11.4	-73.5%	(\$9,713)
12	North Chicago	135	113	74.8	15.8	-59.0	-78.9%	(\$50,260)
12	Tomah	52	44	13.6	2.7	-10.9	-80.4%	(\$9,295)
15	St. Louis	67	48	35.8	13.9	-21.9	-61.2%	(\$18,673)
15	Topeka	104	95	63.3	28.1	-35.1	-55.6%	(\$29,946)
16	Gulf Coast	53	44	67.9	24.0	-43.9	-64.7%	(\$37,430)

VISN	SITE	Total N FY05	1 N 365 Days	2 Pre-IDF MH Days/ Veteran	3 Post-IDF MH Days/ Veteran	4 Change MH Days/ Veteran (col 3-2)	5 % Change MH Days/ (4/2)	6 Change MH Cost*/ Inp't Veteran (4x\$852)
16	Houston	69	61	33.9	13.6	-20.3	-59.8%	(\$17,263)
16	Little Rock	58	43	74.2	59.0	-15.2	-20.4%	(\$12,919)
16	New Orleans	60	48	37.0	12.5	-24.5	-66.1%	(\$20,856)
17	Dallas	81	68	54.1	18.0	-36.1	-66.8%	(\$30,797)
17	San Antonio	38	24	71.1	17.7	-53.4	-75.1%	(\$45,511)
17	Temple (Waco)	73	51	86.5	13.0	-73.5	-85.0%	(\$62,664)
18	Albuquerque	73	61	40.3	25.5	-14.8	-36.7%	(\$12,598)
18	Phoenix	103	77	30.7	16.3	-14.4	-47.0%	(\$12,271)
19	Denver	77	72	65.2	21.6	-43.6	-66.9%	(\$37,157)
19	Fort Harrison	51	36	23.8	2.5	-21.3	-89.5%	(\$18,105)
19	Grand Junction	45	40	25.7	15.7	-10.0	-38.8%	(\$8,477)
19	Salt Lake City	71	53	27.3	15.1	-12.2	-44.8%	(\$10,433)
19	Sheridan	18	16	75.6	26.3	-49.3	-65.2%	(\$42,014)
19	Southern Colorado	93	81	17.0	3.6	-13.4	-79.1%	(\$11,444)
20	American Lake	54	46	87.6	17.7	-69.9	-79.8%	(\$59,566)
20	Boise	40	40	30.3	12.1	-18.2	-60.2%	(\$15,506)
20	Portland	80	65	51.2	19.5	-31.7	-62.0%	(\$27,041)
20	Seattle	63	49	26.8	13.8	-13.0	-48.5%	(\$11,076)
21	Palo Alto	73	38	70.2	23.6	-46.6	-66.4%	(\$39,663)
21	San Francisco	46	38	56.4	9.7	-46.8	-82.8%	(\$39,842)
22	Greater Los Angeles	69	54	88.1	39.6	-48.5	-55.1%	(\$41,354)
22	Long Beach	49	19	59.3	21.2	-38.1	-64.2%	(\$32,466)
22	San Diego	76	42	51.1	9.3	-41.7	-81.7%	(\$35,561)
23	Iowa City	52	45	38.0	13.1	-25.0	-65.6%	(\$21,262)
23	Knoxville	90	79	34.3	7.1	-27.2	-79.4%	(\$23,198)
23	Minneapolis	72	61	92.4	7.4	-85.0	-91.9%	(\$72,378)
23	Omaha	48	35	23.9	5.9	-18.1	-75.4%	(\$15,385)
23	St.Cloud	40	36	38.9	15.6	-23.3	-59.9%	(\$19,880)
ALL SITES		5619	4351	64.8	19.7	-45.2	-69.7%	(\$38,486)
SITE AVERAGE		69	54	61.9	19.3	-42.6	-64.3%	(\$36,317)
SITE STD. DEV.		29	26	42.0	10.7	37.5	16.1%	\$31,779

FY 2005 National general psychiatry per diem = \$852 (NMHPPMS). Unit cost estimates changed this year due to a shift in VHA accounting from the CDR to the Decision Support System

Total N FY05=IDF3 Table <10/01/05 (including terminated)

Shaded values exceed one standard deviation from the mean in undesired direction. Bold /Underlined values represent positive outliers.

Source: VA automated Patient Treatment File FY05; NMHPPMS FY05

TABLE 2-18b. VA HOSPITAL USE 548 DAYS PRE -vs- POST-ENTRY PTF FY05

VISN	SITE	Total N FY05	1 N 548 Days	2 Pre-IDF MH Days/ Veteran	3 Post-IDF MH Days/ Veteran	4 Change MH Days/ Veteran (col 3-2)	5 % Change MH Days/ (4/2)	6 Change MH Cost*/ Inp't Veteran (4x\$852)
1	Bedford	142	120	73.2	43.0	-30.2	-41.3%	(\$25,738)
1	Brockton	80	45	230.0	42.6	-187.3	-81.5%	(\$159,608)
1	Togus	35	24	106.1	37.2	-69.0	-65.0%	(\$58,753)
1	West Haven	67	28	121.6	42.7	-78.9	-64.9%	(\$67,247)
2	Albany	54	35	49.3	15.5	-33.9	-68.7%	(\$28,846)
2	Buffalo	92	56	26.1	19.3	-6.9	-26.3%	(\$5,858)
2	Canandaigua	105	68	184.1	13.0	-171.1	-92.9%	(\$145,742)
2	Syracuse	51	29	41.4	24.7	-16.7	-40.3%	(\$14,190)
3	Brooklyn	60	42	86.3	40.8	-45.5	-52.8%	(\$38,786)
3	Hudson Valley	90	66	351.5	67.4	-284.1	-80.8%	(\$242,045)
3	New Jersey	95	73	92.7	32.6	-60.1	-64.8%	(\$51,237)
3	Northport	114	91	107.7	40.3	-67.4	-62.6%	(\$57,440)
4	Coatesville	109	74	149.3	30.7	-118.6	-79.4%	(\$101,066)
4	Pittsburgh	132	109	97.6	26.8	-70.8	-72.5%	(\$60,304)
5	Baltimore	28	17	107.1	40.9	-66.2	-61.8%	(\$56,382)
5	Martinsburg	49	15	34.7	21.7	-13.1	-37.6%	(\$11,133)
5	Perry Point	71	68	290.0	35.0	-255.0	-87.9%	(\$217,235)
5	Washington, DC	49	20	52.4	16.2	-36.2	-69.1%	(\$30,842)
6	Fayetteville	36	23	64.6	15.0	-49.6	-76.8%	(\$42,267)
6	Hampton	63	42	76.7	25.0	-51.7	-67.4%	(\$44,020)
6	Salem	38	29	46.6	25.6	-21.0	-45.1%	(\$17,921)
6	Salisbury	61	30	197.8	78.1	-119.7	-60.5%	(\$101,956)
7	Atlanta	69	42	47.5	7.5	-40.0	-84.2%	(\$34,121)
7	Augusta	78	70	258.5	29.6	-228.9	-88.5%	(\$194,986)
7	Birmingham	39	21	164.0	66.5	-97.5	-59.4%	(\$83,090)
7	Charleston	35	18	74.7	24.0	-50.7	-67.9%	(\$43,215)
7	Columbia	57	12	74.3	33.4	-40.9	-55.0%	(\$34,861)
7	Tuscaloosa	74	57	165.6	28.7	-136.8	-82.6%	(\$116,589)
7	Tuskegee	61	44	71.9	37.2	-34.7	-48.2%	(\$29,549)
8	Gainesville	57	54	64.9	16.6	-48.4	-74.5%	(\$41,227)
8	Miami	89	51	69.2	35.5	-33.7	-48.7%	(\$28,684)
8	Tampa	55	38	48.1	24.2	-23.9	-49.7%	(\$20,381)
10	Akron	44	21	62.0	44.9	-17.2	-27.7%	(\$14,646)
10	Chillicothe	113	63	96.9	36.7	-60.1	-62.1%	(\$51,242)
10	Cincinnati	147	97	37.1	22.0	-15.1	-40.7%	(\$12,850)
10	Cleveland	146	95	85.5	34.7	-50.8	-59.4%	(\$43,300)
10	Columbus	29	17	48.8	17.7	-31.1	-63.7%	(\$26,462)
10	Dayton	128	75	17.5	13.1	-4.4	-25.2%	(\$3,760)
10	Mansfield	38	23	59.6	20.8	-38.8	-65.1%	(\$33,080)
10	Youngstown	44	34	26.0	8.2	-17.9	-68.6%	(\$15,211)
11	Ann Arbor	54	48	68.8	24.4	-44.4	-64.6%	(\$37,825)
11	Battle Creek	78	63	156.6	68.3	-88.3	-56.4%	(\$75,206)
11	Danville	42	18	12.7	31.9	19.2	151.8%	\$16,377
11	Detroit	88	73	61.0	21.3	-39.8	-65.2%	(\$33,893)
11	Northern Indiana	84	60	94.3	34.9	-59.4	-63.0%	(\$50,609)
12	Chicago-West Side	73	63	79.4	27.9	-51.5	-64.9%	(\$43,898)
12	Madison	50	43	57.4	12.1	-45.3	-78.9%	(\$38,617)
12	Milwaukee	53	23	21.9	5.3	-16.5	-75.5%	(\$14,077)
12	North Chicago	135	111	105.7	24.7	-81.0	-76.6%	(\$68,989)
12	Tomah	52	36	14.4	3.3	-11.1	-76.9%	(\$9,467)
15	St. Louis	67	39	44.5	16.6	-27.9	-62.6%	(\$23,769)

VISN	SITE	Total N FY05	1 N 548 Days	2 Pre-IDF MH Days/ Veteran	3 Post-IDF MH Days/ Veteran	4 Change MH Days/ Veteran (col 3-2)	5 % Change MH Days/ (4/2)	6 Change MH Cost*/ Inpt Veteran (4x\$852)
15	Topeka	104	87	85.6	36.9	-48.7	-56.9%	(\$41,484)
16	Gulf Coast	53	38	79.3	36.3	-43.0	-54.2%	(\$36,636)
16	Houston	69	59	47.3	18.0	-29.3	-61.9%	(\$24,968)
16	Little Rock	58	42	93.8	72.5	-21.3	-22.7%	(\$18,156)
16	New Orleans	60	43	43.1	17.4	-25.7	-59.6%	(\$21,855)
17	Dallas	81	66	63.7	23.7	-39.9	-62.7%	(\$34,028)
17	San Antonio	38	17	82.4	27.1	-55.4	-67.2%	(\$47,161)
17	Temple (Waco)	73	40	128.4	14.6	-113.9	-88.7%	(\$97,000)
18	Albuquerque	73	42	52.2	29.7	-22.5	-43.2%	(\$19,211)
18	Phoenix	103	64	39.6	24.7	-15.0	-37.8%	(\$12,753)
19	Denver	77	69	78.6	31.5	-47.1	-59.9%	(\$40,093)
19	Fort Harrison	51	27	33.9	4.0	-29.9	-88.1%	(\$25,465)
19	Grand Junction	45	33	27.6	22.7	-4.9	-17.7%	(\$4,157)
19	Salt Lake City	71	48	36.0	18.0	-18.0	-50.0%	(\$15,336)
19	Sheridan	18	16	82.8	39.1	-43.7	-52.8%	(\$37,222)
19	Southern Colorado	93	75	23.8	5.4	-18.4	-77.4%	(\$15,700)
20	American Lake	54	43	110.3	23.5	-86.8	-78.7%	(\$73,946)
20	Boise	40	38	35.4	16.0	-19.5	-54.9%	(\$16,592)
20	Portland	80	57	59.8	26.6	-33.1	-55.4%	(\$28,221)
20	Seattle	63	33	34.3	32.7	-1.6	-4.8%	(\$1,394)
21	Palo Alto	73	34	100.2	38.2	-62.0	-61.9%	(\$52,849)
21	San Francisco	46	35	61.6	9.7	-51.9	-84.2%	(\$44,182)
22	Greater Los Angeles	69	51	118.2	48.6	-69.6	-58.9%	(\$59,306)
22	San Diego	76	29	67.1	17.5	-49.7	-74.0%	(\$42,306)
23	Iowa City	52	40	47.8	19.2	-28.5	-59.7%	(\$24,303)
23	Knoxville	90	76	45.7	10.0	-35.6	-78.1%	(\$30,369)
23	Minneapolis	72	58	115.0	10.7	-104.3	<u>-90.7%</u>	(\$88,858)
23	Omaha	48	27	34.6	9.5	-25.1	-72.6%	(\$21,426)
23	St.Cloud	40	34	53.0	28.4	-24.6	-46.5%	(\$20,999)
ALL SITES		5570	3834	89.7	28.1	-61.6	-68.6%	(\$52,444)
SITE AVERAGE		70	48	83.2	27.7	-55.5	-59.1%	(\$47,273)
SITE STD. DEV.		29	24	60.8	15.4	53.4	29.6%	\$45,531

FY 2005 National general psychiatry per diem = \$852 (NMHPPMS). Unit cost estimates changed this year due to a shift in VHA accounting from the CDR to the Decision Support System

Total N FY05=IDF3 Table <10/01/05 (including terminated)

Shaded values exceed one standard deviation from the mean in undesired direction. Bold /Underlined values represent positive outliers.

Source: VA automated Patient Treatment File FY05; NMHPPMS FY05

TABLE 2-18c. VA HOSPITAL USE 730 DAYS PRE -vs- POST-ENTRY PTF FY05

VISN	SITE	Total N FY05	1 N 730 Days	2 Pre-IDF MH Days/ Veteran	3 Post-IDF MH Days/ Veteran	4 Change MH Days/ Veteran (col 3-2)	5 % Change MH Days/ (4/2)	6 Change MH Cost*/ Inp't Veteran (4x\$852)
1	Bedford	142	110	85.8	50.7	-35.1	-40.9%	(\$29,936)
1	Brockton	80	39	319.3	57.5	-261.7	-82.0%	(\$223,006)
1	Togus	35	21	144.8	48.8	-96.0	-66.3%	(\$81,833)
1	West Haven	67	26	147.1	58.3	-88.7	-60.3%	(\$75,599)
2	Albany	54	29	52.8	17.7	-35.1	-66.5%	(\$29,908)
2	Buffalo	92	52	32.0	22.8	-9.2	-28.6%	(\$7,799)
2	Canandaigua	105	67	244.1	20.0	-224.0	-91.8%	(\$190,873)
2	Syracuse	51	27	46.3	31.0	-15.3	-33.0%	(\$13,001)
3	Brooklyn	60	35	90.0	47.1	-42.9	-47.7%	(\$36,539)
3	Hudson Valley	90	63	463.3	88.4	-374.9	-80.9%	(\$319,432)
3	New Jersey	95	69	137.4	39.0	-98.4	-71.6%	(\$83,854)
3	Northport	114	83	169.5	55.3	-114.2	-67.4%	(\$97,282)
4	Coatesville	109	61	199.8	48.6	-151.1	-75.7%	(\$128,778)
4	Pittsburgh	132	101	117.5	35.9	-81.7	-69.5%	(\$69,577)
5	Baltimore	28	15	131.6	52.7	-78.9	-60.0%	(\$67,251)
5	Perry Point	71	66	369.1	44.3	-324.7	-88.0%	(\$276,668)
5	Washington, DC	49	18	67.8	18.3	-49.4	-73.0%	(\$42,127)
6	Fayetteville	36	21	82.8	14.8	-68.0	-82.1%	(\$57,936)
6	Hampton	63	38	77.8	30.7	-47.1	-60.6%	(\$40,156)
6	Salem	38	21	55.9	32.0	-23.8	-42.6%	(\$20,286)
6	Salisbury	61	27	248.9	101.6	-147.3	-59.2%	(\$125,528)
7	Atlanta	69	41	60.9	9.8	-51.0	-83.9%	(\$43,494)
7	Augusta	78	64	337.7	39.9	-297.8	-88.2%	(\$253,723)
7	Birmingham	39	15	255.3	104.1	-151.1	-59.2%	(\$128,766)
7	Tuscaloosa	74	51	204.8	43.1	-161.7	-78.9%	(\$137,757)
7	Tuskegee	61	40	89.1	48.9	-40.2	-45.1%	(\$34,229)
8	Gainesville	57	53	74.2	20.0	-54.2	-73.1%	(\$46,201)
8	Miami	89	50	82.8	43.9	-38.9	-47.0%	(\$33,126)
8	Tampa	55	33	60.1	31.8	-28.3	-47.0%	(\$24,088)
10	Akron	44	16	77.2	52.6	-24.6	-31.9%	(\$20,981)
10	Chillicothe	113	55	139.6	48.7	-90.9	-65.1%	(\$77,439)
10	Cincinnati	147	55	49.7	34.7	-15.1	-30.3%	(\$12,857)
10	Cleveland	146	82	112.7	45.3	-67.4	-59.8%	(\$57,385)
10	Columbus	29	17	58.3	30.3	-28.0	-48.0%	(\$23,856)
10	Dayton	128	38	29.0	26.7	-2.2	-7.7%	(\$1,906)
10	Mansfield	38	10	86.1	19.9	-66.2	-76.9%	(\$56,402)
10	Youngstown	44	28	30.6	12.4	-18.2	-59.4%	(\$15,519)
11	Ann Arbor	54	44	92.0	28.2	-63.8	-69.3%	(\$54,334)
11	Battle Creek	78	58	185.2	84.6	-100.6	-54.3%	(\$85,744)
11	Detroit	88	73	72.5	26.1	-46.3	-63.9%	(\$39,472)
11	Northern Indiana	84	55	129.4	42.9	-86.5	-66.8%	(\$73,690)
12	Chicago-West Side	73	57	92.4	35.5	-57.0	-61.6%	(\$48,549)
12	Madison	50	42	67.9	18.1	-49.8	-73.4%	(\$42,417)
12	Milwaukee	53	19	24.0	10.2	-13.8	-57.7%	(\$11,793)
12	North Chicago	135	103	136.3	34.4	-101.9	-74.8%	(\$86,838)
12	Tomah	52	31	22.6	4.5	-18.1	-80.1%	(\$15,446)
15	St. Louis	67	23	63.4	15.7	-47.7	-75.3%	(\$40,674)
15	Topeka	104	81	106.6	40.1	-66.5	-62.4%	(\$56,663)
16	Gulf Coast	53	35	88.9	45.1	-43.9	-49.3%	(\$37,366)
16	Houston	69	58	56.0	21.6	-34.4	-61.5%	(\$29,306)
16	Little Rock	58	39	111.2	90.1	-21.1	-19.0%	(\$17,979)

VISN	SITE	Total N FY05	1 N 730 Days	2 Pre-IDF MH Days/ Veteran	3 Post-IDF MH Days/ Veteran	4 Change MH Days/ Veteran (col 3-2)	5 % Change MH Days/ (4/2)	6 Change MH Cost*/ Inp't Veteran (4x\$852)
16	New Orleans	60	33	35.5	20.5	-15.0	-42.3%	(\$12,806)
17	Dallas	81	64	76.1	29.2	-47.0	-61.7%	(\$40,004)
17	Temple (Waco)	73	40	142.5	24.1	-118.4	-83.1%	(\$100,877)
18	Albuquerque	73	27	73.0	39.6	-33.5	-45.8%	(\$28,526)
18	Phoenix	103	57	49.3	33.9	-15.4	-31.2%	(\$13,109)
19	Denver	77	65	88.0	41.2	-46.9	-53.2%	(\$39,939)
19	Fort Harrison	51	18	31.2	5.7	-25.5	-81.8%	(\$21,726)
19	Grand Junction	45	32	29.1	32.6	3.5	12.1%	\$3,009
19	Salt Lake City	71	46	47.9	18.7	-29.2	-61.0%	(\$24,893)
19	Sheridan	18	15	83.7	46.3	-37.4	-44.7%	(\$31,865)
19	Southern Colorado	93	74	29.7	8.7	-21.0	-70.7%	(\$17,880)
20	American Lake	54	40	120.7	26.0	-94.8	-78.5%	(\$80,748)
20	Boise	40	34	44.7	20.6	-24.1	-53.9%	(\$20,548)
20	Portland	80	51	72.6	32.0	-40.6	-56.0%	(\$34,615)
20	Seattle	63	28	49.1	46.3	-2.9	-5.9%	(\$2,465)
21	Palo Alto	73	33	122.5	51.5	-71.0	-57.9%	(\$60,492)
21	San Francisco	46	30	68.2	12.7	-55.5	-81.4%	(\$47,286)
22	Greater Los Angeles	69	48	146.4	56.3	-90.1	-61.6%	(\$76,787)
22	San Diego	76	14	86.7	30.6	-56.1	-64.7%	(\$47,834)
23	Iowa City	52	35	54.1	24.1	-29.9	-55.3%	(\$25,487)
23	Knoxville	90	73	57.7	10.7	-46.9	-81.4%	(\$39,997)
23	Minneapolis	72	57	132.0	13.5	-118.5	-89.8%	(\$100,984)
23	Omaha	48	20	43.8	10.1	-33.7	-76.9%	(\$28,712)
23	St.Cloud	40	30	65.8	44.1	-21.7	-33.0%	(\$18,488)
ALL SITES		5349	3319	117.2	36.8	-80.4	-68.6%	(\$68,509)
SITE AVERAGE		71	44	107.1	36.0	-71.0	-59.7%	(\$60,512)
SITE STD. DEV.		29	22	83.3	21.1	72.4	20.5%	\$61,682

FY 2005 National general psychiatry per diem = \$852 (NMHPPMS). Unit cost estimates changed this year due to a shift in VHA accounting from the CDR to the Decision Support System

Total N FY05=IDF3 Table <10/01/05 (including terminated)

Shaded values exceed one standard deviation from the mean in undesired direction. Bold /Underlined values represent positive outliers.
Source: VA automated Patient Treatment File FY05; NMHPPMS FY05

TABLE 2-19. BRIEF PSYCHIATRIC RATING SCALE

Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
1	Bedford	139	37.31	27.35	-9.96	-26.68%
1	Brockton	56	34.68	22.14	-12.54	-36.15%
1	Togus	33	32.85	20.95	-11.90	-36.23%
1	West Haven	36	39.21	34.83	-4.38	-11.18%
2	Albany	30	47.97	42.52	-5.46	-11.37%
2	Buffalo	64	44.12	42.11	-2.01	-4.54%
2	Canandaigua	61	40.14	42.49	2.35	5.84%
2	Syracuse	43	42.79	35.64	-7.15	-16.72%
3	Brooklyn	59	40.59	42.08	1.50	3.68%
3	Hudson Valley	58	44.89	46.42	1.54	3.42%
3	New Jersey	89	40.52	33.27	-7.25	-17.88%
3	Northport	45	41.13	39.76	-1.38	-3.35%
4	Coatesville	107	40.38	35.95	-4.43	-10.97%
4	Lebanon	19	53.58	48.79	-4.79	-8.94%
4	Philadelphia	32	41.59	28.00	-13.59	-32.68%
4	Pittsburgh	129	34.49	26.98	-7.51	-21.78%
5	Baltimore	28	46.09	38.58	-7.51	-16.29%
5	Martinsburg	49	34.98	26.23	-8.74	-25.00%
5	Perry Point	71	45.07	44.39	-0.68	-1.51%
5	Washington, DC	46	47.63	55.18	7.55	15.85%
6	Fayetteville	34	42.76	39.73	-3.04	-7.11%
6	Hampton	43	40.07	32.32	-7.75	-19.35%
6	Salem	32	35.03	22.47	-12.56	-35.85%
6	Salisbury	52	44.02	59.15	15.13	34.38%
7	Atlanta	53	37.87	27.42	-10.45	-27.60%
7	Augusta	78	30.65	22.99	-7.66	-24.99%
7	Birmingham	35	35.90	30.50	-5.40	-15.05%
7	Charleston	35	47.09	41.57	-5.52	-11.71%
7	Columbia	50	39.77	37.02	-2.75	-6.91%
7	Tuscaloosa	54	28.00	20.09	-7.92	-28.27%
7	Tuskegee	55	39.02	25.06	-13.96	-35.78%
8	Gainesville	57	49.95	43.82	-6.12	-12.26%
8	Miami	52	37.15	29.21	-7.94	-21.38%
8	Tampa	25	37.16	48.38	11.22	30.20%
8	West Palm Beach	22	45.39	35.35	-10.03	-22.10%
10	Akron	44	43.92	46.64	2.72	6.19%
10	Chillicothe	90	33.40	26.56	-6.84	-20.48%
10	Cincinnati	141	37.30	34.74	-2.56	-6.87%
10	Cleveland	142	35.39	29.24	-6.14	-17.36%
10	Columbus	29	38.58	44.34	5.76	14.93%
10	Dayton	124	39.80	32.43	-7.37	-18.53%
10	Mansfield	37	33.62	21.52	-12.10	-35.99%
10	Youngstown	42	38.50	28.53	-9.97	-25.89%
11	Ann Arbor	53	41.19	31.19	-10.00	-24.27%
11	Battle Creek	76	37.91	34.66	-3.24	-8.56%
11	Danville	27	30.00	20.93	-9.07	-30.24%
11	Detroit	83	32.45	19.46	-12.99	-40.02%
11	Northern Indiana	46	40.59	35.48	-5.11	-12.59%
12	Chicago-West Side	59	42.31	28.49	-13.81	-32.65%
12	Madison	49	36.88	32.70	-4.18	-11.33%
12	Milwaukee	51	51.63	54.33	2.69	5.21%
12	North Chicago	129	33.37	26.03	-7.34	-22.01%
12	Tomah	27	40.67	37.16	-3.51	-8.62%

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
15	St. Louis	64	58.32	49.77	-8.55	-14.65%
15	Topeka	38	44.29	41.89	-2.40	-5.42%
16	Gulf Coast	52	35.38	31.39	-3.99	-11.28%
16	Houston	69	42.32	34.87	-7.45	-17.60%
16	Little Rock	52	36.75	24.10	<u>-12.65</u>	<u>-34.42%</u>
16	New Orleans	56	46.02	36.67	-9.35	-20.32%
17	Dallas	80	37.95	28.14	-9.81	-25.85%
17	San Antonio	34	46.53	40.53	-6.00	-12.90%
17	Temple (Waco)	72	40.53	33.65	-6.88	-16.97%
18	Albuquerque	72	36.31	36.66	0.35	0.97%
18	Phoenix	70	45.81	38.02	-7.80	-17.02%
19	Denver	77	37.12	32.91	-4.21	-11.35%
19	Fort Harrison	42	45.21	48.72	3.51	7.76%
19	Grand Junction	45	57.11	48.76	-8.35	-14.61%
19	Salt Lake City	67	55.90	54.85	-1.05	-1.88%
19	Sheridan	18	50.22	62.02	11.80	23.49%
19	Southern Colorado	90	33.50	22.66	-10.84	-32.37%
20	American Lake	53	46.86	50.39	3.53	7.54%
20	Boise	39	37.03	30.76	-6.27	-16.93%
20	Portland	61	40.75	35.08	-5.67	-13.91%
20	Seattle	59	54.73	56.81	2.08	3.80%
21	Palo Alto	71	48.79	38.77	-10.02	-20.53%
21	San Francisco	44	43.33	42.65	-0.68	-1.57%
22	Greater Los Angeles	65	49.57	56.67	7.10	14.33%
22	Long Beach	49	41.59	33.88	-7.71	-18.54%
22	San Diego	76	40.82	29.90	<u>-10.92</u>	<u>-26.75%</u>
23	Iowa City	50	37.72	35.17	-2.55	-6.76%
23	Knoxville	90	36.84	26.56	-10.28	-27.90%
23	Minneapolis	71	47.97	51.50	3.52	7.35%
23	Omaha	46	37.78	28.81	-8.97	-23.74%
23	St.Cloud	38	44.89	43.09	-1.80	-4.01%
ALL SITES		4930	40.51	35.25	-5.22	-12.88%
SITE AVERAGE		58.69	41.25	36.41	-4.84	-12.83%
SITE STD DEVIATION		27.83	6.24	10.17	6.08	15.51%

Change values are least squares means derived from analysis of covariance adjusted for site, time, baseline value, and eleven other baseline covariates

Shaded values represent significant t-test differences, in the undesired direction, between LS means for the indicated site and the median site on this variable.

Bold Underlined values represent positive outliers.

Source: Client Interviews

TABLE 2-20. SYMPTOM SEVERITY (BSI GLOBAL SCALE)

Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
1	Bedford	140	1.99	1.47	-0.52	-26.16%
1	Brockton	53	1.57	1.10	-0.48	-30.31%
1	Togus	32	1.92	1.40	-0.51	-26.79%
1	West Haven	36	2.00	1.91	-0.09	-4.38%
2	Albany	30	2.09	1.89	-0.20	-9.61%
2	Buffalo	65	2.25	2.17	-0.08	-3.50%
2	Canandaigua	61	2.01	2.09	0.08	3.81%
2	Syracuse	43	2.20	2.17	-0.03	-1.59%
3	Brooklyn	58	2.05	1.85	-0.19	-9.43%
3	Hudson Valley	54	2.00	1.79	-0.22	-10.77%
3	New Jersey	88	2.06	1.63	-0.43	-20.99%
3	Northport	42	1.88	1.78	-0.11	-5.73%
4	Coatesville	106	1.91	1.70	-0.21	-10.80%
4	Lebanon	20	2.34	2.24	-0.10	-4.27%
4	Philadelphia	32	2.15	1.62	-0.53	-24.49%
4	Pittsburgh	123	1.72	1.38	-0.34	-19.95%
5	Baltimore	27	2.17	2.24	0.07	3.33%
5	Martinsburg	48	2.20	2.12	-0.08	-3.60%
5	Perry Point	59	1.65	1.30	-0.35	-21.34%
5	Washington, DC	47	2.38	2.52	0.14	5.68%
6	Fayetteville	34	2.16	1.94	-0.22	-10.11%
6	Hampton	42	2.18	2.02	-0.16	-7.33%
6	Salem	31	1.86	1.47	-0.40	-21.38%
6	Salisbury	51	1.99	2.34	0.35	17.70%
7	Atlanta	53	2.07	1.73	-0.35	-16.76%
7	Augusta	78	1.85	1.67	-0.18	-9.73%
7	Birmingham	33	1.82	1.34	-0.49	-26.73%
7	Charleston	35	2.29	2.28	-0.02	-0.67%
7	Columbia	46	2.01	1.75	-0.26	-13.05%
7	Tuscaloosa	52	1.61	1.08	-0.53	-33.04%
7	Tuskegee	55	2.13	2.27	0.14	6.57%
8	Gainesville	57	2.12	1.96	-0.16	-7.56%
8	Miami	52	1.99	1.72	-0.27	-13.32%
8	Tampa	23	1.94	1.75	-0.19	-9.72%
8	West Palm Beach	24	2.21	1.75	-0.46	-20.87%
10	Akron	43	2.05	2.11	0.06	3.13%
10	Chillicothe	87	1.72	1.49	-0.24	-13.67%
10	Cincinnati	141	2.05	1.85	-0.20	-9.67%
10	Cleveland	132	1.79	1.60	-0.19	-10.81%
10	Columbus	28	2.21	2.10	-0.10	-4.75%
10	Dayton	123	2.05	1.81	-0.25	-12.07%
10	Mansfield	35	1.71	1.27	-0.44	-25.60%
10	Youngstown	42	1.91	1.55	-0.37	-19.16%
11	Ann Arbor	52	2.02	1.64	-0.37	-18.47%
11	Battle Creek	73	1.93	1.80	-0.14	-7.00%
11	Danville	27	2.07	2.20	0.13	6.23%
11	Detroit	82	1.91	1.59	-0.32	-16.97%
11	Northern Indiana	42	1.99	1.81	-0.18	-9.09%
12	Chicago-West Side	59	2.09	1.28	-0.81	-38.80%
12	Madison	49	1.89	1.88	-0.02	-0.82%
12	Milwaukee	51	2.14	1.97	-0.17	-8.01%
12	North Chicago	126	1.81	1.45	-0.36	-20.00%
12	Tomah	27	1.80	1.73	-0.07	-3.91%
15	St. Louis	64	2.52	1.94	-0.58	-22.90%
15	Topeka	37	2.20	1.91	-0.29	-13.12%
16	Gulf Coast	51	2.00	1.80	-0.20	-10.03%
16	Houston	67	2.12	1.73	-0.40	-18.66%

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
16	Little Rock	50	2.01	1.69	-0.32	-15.84%
16	New Orleans	50	2.09	1.66	-0.43	-20.67%
17	Dallas	79	2.06	1.98	-0.08	-3.87%
17	San Antonio	32	2.24	2.27	0.03	1.48%
17	Temple (Waco)	72	2.20	2.15	-0.05	-2.46%
18	Albuquerque	71	2.10	1.99	-0.10	-5.00%
18	Phoenix	69	2.24	1.99	-0.25	-11.37%
19	Denver	76	1.93	1.66	-0.27	-14.04%
19	Fort Harrison	42	2.27	2.25	-0.02	-0.88%
19	Grand Junction	45	2.63	2.25	-0.38	-14.56%
19	Salt Lake City	66	2.19	1.76	-0.43	-19.46%
19	Sheridan	18	2.27	2.70	0.42	18.57%
19	Southern Colorado	86	2.03	1.74	-0.29	-14.07%
20	American Lake	48	2.12	1.94	-0.19	-8.81%
20	Boise	38	2.07	1.79	-0.28	-13.56%
20	Portland	47	1.87	1.77	-0.11	-5.76%
20	Seattle	59	2.29	2.10	-0.19	-8.48%
21	Palo Alto	70	2.08	1.60	-0.48	-23.09%
21	San Francisco	44	2.03	1.91	-0.11	-5.54%
22	Greater Los Angeles	59	2.19	2.24	0.05	2.20%
22	Long Beach	48	1.91	1.63	-0.28	-14.62%
22	San Diego	75	2.14	1.66	-0.49	-22.70%
23	Iowa City	50	2.02	1.72	-0.30	-14.72%
23	Knoxville	88	1.81	1.48	-0.34	-18.61%
23	Minneapolis	68	2.05	1.76	-0.29	-14.34%
23	Omaha	46	1.89	1.73	-0.16	-8.70%
23	St.Cloud	38	2.20	1.82	-0.39	-17.59%
ALL SITES		4802	1.79	1.55	-0.24	-13.55%
SITE AVERAGE		57.17	2.04	1.82	-0.22	-11.16%
SITE STD DEVIATION		27.18	0.19	0.31	0.21	10.38%

Change values are least squares means derived from analysis of covariance adjusted for site, time, baseline value, and eleven other baseline covariates

Shaded values represent significant t-test differences, in the undesired direction, between LS means for the indicated site and the median site on this variable.

Bold/Underlined values represent positive outliers.

Source: Client Interviews

TABLE 2-21. GLOBAL ASSESSMENT OF FUNCTIONING

Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
1	Bedford	137	40.95	42.62	1.67	4.09%
1	Brockton	56	31.46	24.81	-6.66	-21.15%
1	Togus	33	41.00	36.50	-4.50	-10.97%
1	West Haven	36	31.83	28.79	-3.04	-9.56%
2	Albany	30	37.87	40.04	2.17	5.74%
2	Buffalo	62	36.26	35.65	-0.61	-1.67%
2	Canandaigua	61	33.85	27.57	-6.29	-18.57%
2	Syracuse	43	43.30	47.78	4.48	10.35%
3	Brooklyn	57	40.96	46.35	5.38	13.14%
3	Hudson Valley	58	39.84	36.71	-3.13	-7.86%
3	New Jersey	88	42.86	44.83	1.96	4.58%
3	Northport	45	46.73	54.10	7.37	15.77%
4	Coatesville	107	41.34	46.34	5.00	12.10%
4	Lebanon	18	37.56	52.99	15.44	41.10%
4	Philadelphia	32	43.34	57.00	13.66	31.51%
4	Pittsburgh	127	39.03	44.23	5.19	13.31%
5	Baltimore	27	43.11	53.41	10.30	23.88%
5	Martinsburg	48	42.08	44.41	2.33	5.54%
5	Perry Point	71	38.56	35.90	-2.67	-6.91%
5	Washington, DC	46	43.50	46.59	3.09	7.11%
6	Fayetteville	34	45.97	52.64	6.67	14.52%
6	Hampton	43	40.77	46.19	5.42	13.30%
6	Salem	32	45.03	52.07	7.04	15.63%
6	Salisbury	52	39.65	38.48	-1.17	-2.96%
7	Atlanta	53	43.74	56.32	12.59	28.78%
7	Augusta	78	42.73	45.91	3.18	7.44%
7	Birmingham	35	43.80	48.54	4.74	10.83%
7	Charleston	35	31.74	29.92	-1.82	-5.74%
7	Columbia	49	45.71	57.43	11.71	25.62%
7	Tuscaloosa	54	42.93	49.05	6.12	14.27%
7	Tuskegee	54	47.52	51.30	3.78	7.95%
8	Gainesville	57	41.61	41.24	-0.37	-0.89%
8	Miami	50	39.38	45.19	5.81	14.77%
8	Tampa	25	51.24	62.29	11.05	21.56%
8	West Palm Beach	21	40.00	48.47	8.47	21.18%
10	Akron	44	38.61	44.43	5.81	15.05%
10	Chillicothe	90	41.86	48.89	7.04	16.82%
10	Cincinnati	141	45.71	54.16	8.45	18.49%
10	Cleveland	142	36.73	37.64	0.90	2.46%
10	Columbus	29	45.97	55.87	9.90	21.55%
10	Dayton	123	46.03	49.65	3.62	7.86%
10	Mansfield	35	37.17	35.80	-1.37	-3.70%
10	Youngstown	43	45.19	40.15	-5.03	-11.14%
11	Ann Arbor	53	36.15	34.71	-1.44	-3.99%
11	Battle Creek	76	45.12	49.04	3.92	8.70%
11	Danville	26	48.92	60.86	11.93	24.39%
11	Detroit	81	44.25	53.98	9.73	22.00%
11	Northern Indiana	46	46.04	50.55	4.50	9.78%
12	Chicago-West Side	59	43.56	42.52	-1.04	-2.38%
12	Madison	49	43.20	44.01	0.81	1.88%
12	Milwaukee	51	42.41	47.16	4.75	11.21%
12	North Chicago	128	35.23	29.35	-5.89	-16.71%

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
12	Tomah	27	37.44	37.82	0.37	0.99%
15	St. Louis	58	44.52	54.01	9.49	<u>21.33%</u>
15	Topeka	36	39.44	38.32	-1.12	-2.85%
16	Gulf Coast	51	48.33	54.80	6.47	13.39%
16	Houston	68	40.76	45.68	4.91	12.05%
16	Little Rock	52	25.88	16.29	-9.59	-37.05%
16	New Orleans	53	34.36	35.95	1.59	4.63%
17	Dallas	80	39.64	40.85	1.21	3.06%
17	San Antonio	35	37.51	46.53	9.02	<u>24.04%</u>
17	Temple (Waco)	72	40.72	42.30	1.58	3.88%
18	Albuquerque	72	38.13	40.60	2.48	6.50%
18	Phoenix	67	44.51	48.18	3.67	8.25%
19	Denver	77	37.32	42.94	5.61	15.04%
19	Fort Harrison	43	48.63	53.66	5.04	10.36%
19	Grand Junction	45	35.20	36.02	0.82	2.33%
19	Salt Lake City	67	34.25	40.94	6.69	19.52%
19	Sheridan	18	47.89	57.94	10.05	<u>20.99%</u>
19	Southern Colorado	90	42.84	47.13	4.29	10.00%
20	American Lake	53	37.87	32.19	-5.68	-14.99%
20	Boise	39	39.87	37.94	-1.93	-4.85%
20	Portland	61	28.90	31.40	2.49	8.63%
20	Seattle	58	39.17	42.56	3.39	8.66%
21	Palo Alto	71	40.35	51.06	10.71	<u>26.54%</u>
21	San Francisco	45	37.80	47.86	10.06	<u>26.61%</u>
22	Greater Los Angeles	64	45.17	46.17	1.00	2.21%
22	Long Beach	48	45.35	51.74	6.39	14.09%
22	San Diego	75	39.32	43.37	4.05	10.29%
23	Iowa City	50	28.50	35.17	6.67	23.39%
23	Knoxville	90	34.80	36.64	1.84	5.29%
23	Minneapolis	69	33.84	28.43	-5.41	-16.00%
23	Omaha	46	35.24	41.70	6.46	18.33%
23	St.Cloud	38	43.29	47.29	4.00	9.25%
ALL SITES		4888	40.36	42.56	2.98	7.38%
SITE AVERAGE		58.19	40.55	43.36	2.81	7.50%
SITE STD DEVIATION		27.65	4.97	8.76	5.14	13.18%

Change values are least squares means derived from analysis of covariance adjusted for site, time, baseline value, and eleven other baseline covariates

Shaded values represent significant t-test differences, in the undesired direction, between LS means for the indicated site and the median site on this variable.

Bold/Underlined values represent positive outliers.

Source: Client Interviews

TABLE 2-22. INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
1	Bedford	134	47.66	53.94	6.28	13.18%
1	Brockton	45	45.59	49.56	3.97	8.70%
1	Togus	32	46.07	48.52	2.46	5.33%
1	West Haven	30	43.76	46.21	2.45	5.59%
2	Albany	26	47.39	49.63	2.23	4.71%
2	Buffalo	58	43.60	47.02	3.43	7.86%
2	Canandaigua	45	44.29	44.72	0.42	0.96%
2	Syracuse	43	43.61	44.74	1.14	2.60%
3	Brooklyn	57	44.29	44.16	-0.13	-0.29%
3	Hudson Valley	25	31.79	26.85	-4.94	-15.54%
3	New Jersey	68	40.97	39.02	-1.95	-4.76%
3	Northport	40	39.93	37.79	-2.15	-5.38%
4	Coatesville	91	42.21	40.49	-1.72	-4.07%
4	Lebanon	13	44.05	46.58	2.53	5.74%
4	Philadelphia	31	46.10	48.85	2.75	5.96%
4	Pittsburgh	125	47.07	49.90	2.83	6.02%
5	Baltimore	24	42.87	45.27	2.40	5.59%
5	Martinsburg	49	48.55	51.74	3.20	6.58%
5	Perry Point	41	39.91	40.29	0.38	0.94%
5	Washington, DC	46	47.22	51.57	4.36	9.23%
6	Fayetteville	29	46.04	48.10	2.05	4.46%
6	Hampton	42	45.65	47.89	2.24	4.91%
6	Salem	24	52.62	58.87	6.25	11.87%
6	Salisbury	41	42.48	42.91	0.43	1.02%
7	Atlanta	49	45.59	46.94	1.35	2.96%
7	Augusta	51	43.43	46.74	3.32	7.64%
7	Birmingham	32	46.39	51.24	4.86	10.47%
7	Charleston	35	42.61	39.03	-3.58	-8.40%
7	Columbia	43	41.65	43.74	2.09	5.01%
7	Tuscaloosa	43	39.98	36.12	-3.86	-9.66%
7	Tuskegee	54	40.69	43.80	3.12	7.66%
8	Gainesville	47	42.22	44.75	2.53	5.99%
8	Miami	47	45.13	46.32	1.19	2.65%
8	Tampa	22	46.90	48.48	1.59	3.38%
8	West Palm Beach	23	47.15	46.34	-0.81	-1.71%
10	Akron	41	45.09	44.50	-0.59	-1.32%
10	Chillicothe	28	49.60	56.06	6.46	13.03%
10	Cincinnati	139	47.94	51.74	3.81	7.94%
10	Cleveland	129	46.21	47.67	1.46	3.17%
10	Columbus	29	45.58	47.71	2.13	4.67%
10	Dayton	122	49.19	52.16	2.97	6.05%
10	Mansfield	27	39.89	35.12	-4.77	-11.96%
10	Youngstown	33	46.03	45.43	-0.61	-1.32%
11	Ann Arbor	44	45.18	49.41	4.23	9.37%
11	Battle Creek	60	40.93	41.29	0.36	0.87%
11	Danville	26	46.97	46.90	-0.07	-0.16%
11	Detroit	73	44.32	45.85	1.53	3.46%
11	Northern Indiana	41	42.40	42.11	-0.29	-0.69%
12	Chicago-West Side	58	42.48	50.91	8.43	19.84%
12	Madison	45	47.62	50.77	3.14	6.60%
12	Milwaukee	50	44.53	43.58	-0.95	-2.13%
12	North Chicago	92	47.76	48.94	1.19	2.48%
12	Tomah	21	50.08	54.41	4.33	8.64%

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
15	St. Louis	53	44.17	46.39	2.22	5.03%
15	Topeka	32	45.71	44.86	-0.85	-1.86%
16	Gulf Coast	52	45.76	47.86	2.09	4.58%
16	Houston	69	40.91	39.78	-1.13	-2.75%
16	Little Rock	39	39.97	41.28	1.32	3.30%
16	New Orleans	49	45.04	46.86	1.82	4.04%
17	Dallas	78	45.29	43.54	-1.75	-3.86%
17	San Antonio	27	43.78	42.72	-1.06	-2.41%
17	Temple (Waco)	67	48.84	58.03	9.19	<u>18.82%</u>
18	Albuquerque	64	49.59	52.07	2.48	5.01%
18	Phoenix	56	45.52	44.05	-1.47	-3.23%
19	Denver	69	44.66	48.61	3.94	8.83%
19	Fort Harrison	43	47.50	49.24	1.74	3.67%
19	Grand Junction	45	44.13	43.69	-0.44	-1.00%
19	Salt Lake City	63	46.63	51.33	4.70	10.08%
19	Sheridan	18	48.58	49.19	0.62	1.27%
19	Southern Colorado	57	43.58	46.11	2.53	5.80%
20	American Lake	48	43.82	46.11	2.29	5.23%
20	Boise	38	47.09	45.69	-1.40	-2.98%
20	Portland	51	39.85	40.27	0.42	1.05%
20	Seattle	58	40.98	40.10	-0.88	-2.14%
21	Palo Alto	62	36.18	35.35	-0.83	-2.30%
21	San Francisco	38	43.59	43.49	-0.10	-0.23%
22	Greater Los Angeles	59	43.60	46.65	3.05	7.00%
22	Long Beach	37	50.30	55.31	5.01	9.95%
22	San Diego	64	45.90	53.00	7.11	<u>15.48%</u>
23	Iowa City	48	46.18	45.43	-0.75	-1.62%
23	Knoxville	82	45.88	49.34	3.46	7.54%
23	Minneapolis	52	44.48	47.48	3.00	6.75%
23	Omaha	46	45.18	45.35	0.17	0.38%
23	St.Cloud	29	48.13	54.08	5.94	12.35%
ALL SITES		4256	44.89	46.20	1.75	3.89%
SITE AVERAGE		50.67	44.74	46.38	1.64	3.42%
SITE STD DEVIATION		25.70	3.24	5.28	2.73	6.16%

Change values are least squares means derived from analysis of covariance adjusted for site, time, baseline value, and eleven other baseline covariates

Shaded values represent significant t-test differences, in the undesired direction, between LS means for the indicated site and the median site on this variable.

Bold/Underlined values represent positive outliers.

Source: Client Interviews

TABLE 2-23. QUALITY OF LIFE

Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
1	Bedford	134	25.15	29.53	4.38	17.41%
1	Brockton	49	28.21	32.34	4.13	14.65%
1	Togus	31	26.72	29.72	3.00	11.21%
1	West Haven	34	23.26	26.47	3.21	13.81%
2	Albany	24	25.01	25.19	0.18	0.72%
2	Buffalo	61	25.63	26.49	0.87	3.38%
2	Canandaigua	57	26.08	27.41	1.32	5.07%
2	Syracuse	40	24.64	25.31	0.67	2.70%
3	Brooklyn	59	25.34	27.84	2.50	9.87%
3	Hudson Valley	55	25.05	26.14	1.09	4.37%
3	New Jersey	84	25.24	27.91	2.67	10.60%
3	Northport	41	24.70	27.61	2.91	11.79%
4	Coatesville	98	25.84	27.77	1.93	7.48%
4	Lebanon	20	24.30	30.75	6.45	26.53%
4	Philadelphia	26	25.29	30.43	5.14	20.33%
4	Pittsburgh	113	27.17	30.13	2.96	10.90%
5	Baltimore	22	25.58	28.07	2.49	9.72%
5	Martinsburg	42	26.97	29.02	2.05	7.61%
5	Perry Point	65	28.44	31.93	3.49	12.26%
5	Washington, DC	43	24.84	26.93	2.09	8.42%
6	Fayetteville	30	25.04	28.83	3.79	15.14%
6	Hampton	38	26.79	30.84	4.05	15.13%
6	Salem	29	25.82	30.12	4.30	16.64%
6	Salisbury	49	26.60	28.20	1.60	6.00%
7	Atlanta	49	27.40	29.58	2.18	7.94%
7	Augusta	73	27.15	28.96	1.82	6.69%
7	Birmingham	31	26.44	29.02	2.59	9.78%
7	Charleston	32	24.89	25.10	0.21	0.83%
7	Columbia	41	26.11	29.66	3.56	13.62%
7	Tuscaloosa	49	28.23	31.31	3.08	10.93%
7	Tuskegee	53	27.40	30.17	2.76	10.08%
8	Gainesville	55	26.11	27.43	1.32	5.05%
8	Miami	48	27.34	31.45	4.11	15.03%
8	Tampa	21	27.26	28.19	0.93	3.43%
8	West Palm Beach	20	25.14	30.70	5.56	22.12%
10	Akron	39	27.51	30.46	2.95	10.73%
10	Chillicothe	81	27.14	30.75	3.60	13.28%
10	Cincinnati	123	25.96	27.81	1.84	7.09%
10	Cleveland	117	27.00	29.21	2.21	8.18%
10	Columbus	27	27.56	29.74	2.18	7.92%
10	Dayton	114	26.39	29.24	2.84	10.78%
10	Mansfield	32	26.78	31.34	4.57	17.06%
10	Youngstown	36	27.10	28.88	1.78	6.57%
11	Ann Arbor	48	25.43	29.62	4.20	16.52%
11	Battle Creek	69	26.60	27.13	0.53	1.99%
11	Danville	24	26.00	28.24	2.24	8.60%
11	Detroit	76	27.73	31.21	3.48	12.54%
11	Northern Indiana	38	27.06	29.32	2.25	8.33%
12	Chicago-West Side	56	25.96	28.13	2.17	8.35%
12	Madison	42	26.50	29.40	2.89	10.91%
12	Milwaukee	45	27.28	30.81	3.53	12.95%
12	North Chicago	124	26.01	29.10	3.09	11.89%

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
12	Tomah	22	27.76	31.51	3.74	13.48%
15	St. Louis	54	24.13	29.51	<u>5.38</u>	<u>22.28%</u>
15	Topeka	36	25.97	30.14	4.17	16.06%
16	Gulf Coast	45	26.61	28.26	1.64	6.18%
16	Houston	62	24.79	28.55	3.76	15.16%
16	Little Rock	44	24.65	26.72	2.06	8.36%
16	New Orleans	55	26.42	31.46	5.04	19.08%
17	Dallas	75	25.72	28.25	2.53	9.83%
17	San Antonio	31	25.20	27.37	2.17	8.62%
17	Temple (Waco)	70	25.51	26.09	0.58	2.28%
18	Albuquerque	63	27.58	29.01	1.42	5.17%
18	Phoenix	54	25.36	27.17	1.82	7.17%
19	Denver	67	26.06	26.87	0.81	3.11%
19	Fort Harrison	34	25.52	28.34	2.83	11.07%
19	Grand Junction	39	26.28	29.28	3.00	11.42%
19	Salt Lake City	61	24.79	29.59	4.81	19.40%
19	Sheridan	17	25.48	25.65	0.17	0.67%
19	Southern Colorado	73	26.93	29.03	2.10	7.81%
20	American Lake	52	25.18	27.70	2.52	10.01%
20	Boise	36	27.46	29.27	1.82	6.61%
20	Portland	40	25.46	26.94	1.48	5.80%
20	Seattle	55	24.15	25.50	1.35	5.59%
21	Palo Alto	63	24.30	26.82	2.52	10.36%
21	San Francisco	40	23.89	25.18	1.29	5.39%
22	Greater Los Angeles	58	23.88	26.43	2.55	10.70%
22	Long Beach	40	25.70	30.48	4.78	18.62%
22	San Diego	69	24.86	29.64	4.77	19.20%
23	Iowa City	45	27.79	30.93	3.14	11.30%
23	Knoxville	78	26.70	31.60	<u>4.90</u>	<u>18.36%</u>
23	Minneapolis	69	26.12	27.06	0.95	3.62%
23	Omaha	40	28.02	30.06	2.04	7.27%
23	St.Cloud	34	26.19	29.03	2.84	10.83%
ALL SITES		4428	26.10	28.98	2.65	10.14%
SITE AVERAGE		52.71	26.07	28.77	2.70	10.38%
SITE STD DEVIATION		25.42	1.16	1.79	1.37	5.39%

Change values are least squares means derived from analysis of covariance adjusted for site, time, baseline value, and eleven other baseline covariates

Shaded values represent significant t-test differences, in the undesired direction, between LS means for the indicated site and the median site on this variable.

Bold/Underlined values represent positive outliers.

Source: Client Interviews

TABLE 2-23a. HOUSING INDEPENDENCE

Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
1	Bedford	139	2.66	3.19	0.52	19.67%
1	Brockton	56	2.63	3.08	0.45	17.09%
1	Togus	33	3.31	3.86	0.55	16.67%
1	West Haven	35	2.98	2.91	-0.07	-2.37%
2	Albany	28	2.96	3.37	0.41	13.71%
2	Buffalo	70	3.57	4.09	0.52	14.53%
2	Canandaigua	61	3.11	3.35	0.23	7.52%
2	Syracuse	43	3.12	3.81	0.69	22.08%
3	Brooklyn	58	3.48	3.93	0.45	13.07%
3	Hudson Valley	58	2.18	2.29	0.12	5.41%
3	New Jersey	91	3.05	3.34	0.29	9.41%
3	Northport	44	2.50	2.82	0.32	12.86%
4	Coatesville	103	2.45	2.65	0.20	8.29%
4	Lebanon	18	3.28	3.87	0.59	17.86%
4	Philadelphia	32	3.27	4.04	0.77	23.53%
4	Pittsburgh	126	3.28	3.98	0.70	21.25%
5	Baltimore	28	2.91	3.44	0.53	18.30%
5	Martinsburg	45	3.07	3.46	0.39	12.56%
5	Perry Point	65	2.12	1.91	-0.21	-10.03%
5	Washington, DC	44	3.25	3.63	0.38	11.62%
6	Fayetteville	33	3.11	3.61	0.50	15.94%
6	Hampton	42	3.08	3.49	0.41	13.32%
6	Salem	32	2.92	3.75	0.83	28.40%
6	Salisbury	51	2.46	2.57	0.11	4.43%
7	Atlanta	53	3.47	4.20	0.73	21.04%
7	Augusta	77	2.40	2.65	0.25	10.48%
7	Birmingham	34	2.67	3.39	0.72	27.14%
7	Charleston	35	3.02	3.38	0.36	11.93%
7	Columbia	48	3.06	3.51	0.45	14.62%
7	Tuscaloosa	53	3.02	3.35	0.33	11.06%
7	Tuskegee	55	3.60	3.95	0.35	9.80%
8	Gainesville	56	3.33	3.57	0.24	7.16%
8	Miami	53	3.58	3.99	0.41	11.46%
8	Tampa	21	2.83	3.22	0.39	13.80%
8	West Palm Beach	24	3.00	3.78	0.78	25.86%
10	Akron	44	3.32	3.83	0.50	15.16%
10	Chillicothe	89	2.41	2.82	0.41	17.03%
10	Cincinnati	140	3.34	3.87	0.53	15.80%
10	Cleveland	142	3.08	3.44	0.36	11.82%
10	Columbus	28	3.42	4.15	0.73	21.37%
10	Dayton	122	3.64	4.33	0.69	18.92%
10	Mansfield	36	3.06	3.36	0.30	9.83%
10	Youngstown	43	3.14	3.77	0.62	19.87%
11	Ann Arbor	53	3.32	3.71	0.39	11.62%
11	Battle Creek	76	2.77	2.92	0.15	5.24%
11	Danville	27	2.24	2.89	0.65	28.89%
11	Detroit	83	2.85	3.37	0.52	18.32%
11	Northern Indiana	46	1.83	2.32	0.50	27.07%
12	Chicago-West Side	58	2.96	3.38	0.42	14.11%
12	Madison	49	2.70	3.40	0.70	25.89%
12	Milwaukee	51	3.40	4.01	0.61	18.04%
12	North Chicago	125	2.56	2.56	0.01	0.23%
12	Tomah	24	2.83	3.83	1.01	35.61%

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
15	St. Louis	64	2.96	3.37	0.41	13.93%
15	Topeka	38	2.79	3.25	0.46	16.55%
16	Gulf Coast	52	2.80	3.28	0.48	17.19%
16	Houston	69	3.02	3.36	0.33	11.00%
16	Little Rock	33	2.72	2.52	-0.20	-7.48%
16	New Orleans	56	2.63	3.50	0.87	32.99%
17	Dallas	80	3.37	3.87	0.51	15.12%
17	San Antonio	33	3.23	3.45	0.23	7.02%
17	Temple (Waco)	72	2.96	3.58	0.61	20.73%
18	Albuquerque	72	3.38	3.83	0.45	13.43%
18	Phoenix	69	3.02	3.04	0.02	0.65%
19	Denver	77	3.02	3.08	0.06	1.94%
19	Fort Harrison	43	3.53	4.41	0.88	25.02%
19	Grand Junction	45	3.27	4.07	0.80	24.59%
19	Salt Lake City	66	3.26	3.71	0.46	13.97%
19	Sheridan	18	3.59	4.52	0.93	25.95%
19	Southern Colorado	90	3.24	3.62	0.38	11.79%
20	American Lake	50	2.83	3.55	0.72	25.27%
20	Boise	38	3.30	3.07	-0.23	-6.95%
20	Portland	60	3.37	3.82	0.45	13.22%
20	Seattle	61	3.14	3.48	0.34	10.75%
21	Palo Alto	68	2.46	2.54	0.09	3.52%
21	San Francisco	45	2.87	3.17	0.30	10.43%
22	Greater Los Angeles	63	2.84	2.56	-0.28	-9.88%
22	Long Beach	46	2.85	2.90	0.04	1.53%
22	San Diego	76	2.73	3.00	0.26	9.58%
23	Iowa City	50	3.25	3.72	0.47	14.58%
23	Knoxville	90	2.93	3.66	0.73	24.89%
23	Minneapolis	71	3.16	3.29	0.13	4.15%
23	Omaha	45	2.92	3.10	0.18	6.16%
23	St.Cloud	36	3.33	3.97	0.64	19.28%
ALL SITES		4856	3.00	3.38	0.40	13.24%
SITE AVERAGE		57.81	3.00	3.42	0.42	13.87%
SITE STD DEVIATION		27.82	0.37	0.52	0.27	9.14%

Change values are least squares means derived from analysis of covariance adjusted for site, time, baseline value, and eleven other baseline covariates

Shaded values represent significant t-test differences, in the undesired direction, between LS means for the indicated site and the median site on this variable.

Bold/Underlined values represent positive outliers.

Source: Client Interviews

TABLE 2-24. VA MENTAL HEALTH SERVICE SATISFACTION

Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
1	Bedford	131	9.59	10.94	1.35	14.08%
1	Brockton	50	9.44	10.15	0.71	7.57%
1	Togus	30	8.93	9.25	0.32	3.60%
1	West Haven	33	8.48	9.25	0.77	9.03%
2	Albany	29	10.66	11.59	0.93	8.73%
2	Buffalo	56	10.32	11.27	0.95	9.16%
2	Canandaigua	57	9.81	9.89	0.08	0.84%
2	Syracuse	41	10.07	10.98	0.90	8.98%
3	Brooklyn	51	9.33	10.08	0.75	8.00%
3	Hudson Valley	53	8.87	9.29	0.43	4.81%
3	New Jersey	88	8.95	9.69	0.73	8.16%
3	Northport	42	9.21	10.17	0.95	10.33%
4	Coatesville	93	9.24	10.03	0.79	8.57%
4	Lebanon	19	9.42	11.34	1.92	20.42%
4	Philadelphia	32	10.41	10.62	0.21	2.04%
4	Pittsburgh	121	9.33	9.94	0.60	6.48%
5	Baltimore	26	9.38	10.47	1.09	11.61%
5	Martinsburg	48	10.19	10.33	0.15	1.44%
5	Perry Point	55	9.73	10.59	0.86	8.85%
5	Washington, DC	42	9.57	9.52	-0.05	-0.53%
6	Fayetteville	33	9.36	10.07	0.71	7.58%
6	Hampton	39	9.92	11.25	1.33	13.41%
6	Salem	31	9.39	10.06	0.67	7.19%
6	Salisbury	49	9.57	10.36	0.79	8.25%
7	Atlanta	48	9.60	11.00	1.40	14.58%
7	Augusta	74	9.03	9.74	0.72	7.94%
7	Birmingham	33	9.45	9.67	0.22	2.31%
7	Charleston	32	9.53	10.83	1.30	13.60%
7	Columbia	42	10.40	11.99	1.58	15.22%
7	Tuscaloosa	48	9.98	11.38	1.40	14.03%
7	Tuskegee	53	9.64	10.55	0.91	9.44%
8	Gainesville	54	8.06	9.27	1.21	15.07%
8	Miami	49	10.02	11.04	1.01	10.13%
8	Tampa	21	10.76	10.88	0.11	1.06%
8	West Palm Beach	24	10.58	12.06	1.48	13.96%
10	Akron	43	9.53	10.85	1.32	13.83%
10	Chillicothe	87	8.59	8.88	0.30	3.47%
10	Cincinnati	130	10.80	11.25	0.45	4.21%
10	Cleveland	125	9.92	10.15	0.23	2.37%
10	Columbus	28	9.32	10.06	0.74	7.91%
10	Dayton	113	10.03	10.67	0.64	6.39%
10	Mansfield	34	10.21	11.25	1.05	10.25%
10	Youngstown	38	9.95	11.44	1.50	15.04%
11	Ann Arbor	44	8.70	10.20	1.49	17.14%
11	Battle Creek	68	8.76	9.21	0.45	5.09%
11	Danville	25	9.04	9.86	0.82	9.04%
11	Detroit	73	10.16	10.94	0.77	7.58%
11	Northern Indiana	38	8.97	9.27	0.29	3.28%
12	Chicago-West Side	57	9.19	9.61	0.41	4.51%
12	Madison	45	9.60	10.06	0.46	4.82%
12	Milwaukee	49	10.65	11.94	1.29	12.12%
12	North Chicago	118	9.42	10.24	0.82	8.76%
12	Tomah	26	10.19	11.19	0.99	9.76%
15	St. Louis	58	9.48	10.33	0.84	8.90%

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
15	Topeka	34	9.76	10.08	0.32	3.23%
16	Gulf Coast	50	9.92	11.07	1.15	11.54%
16	Houston	61	10.03	11.27	1.24	12.31%
16	Little Rock	49	9.84	10.74	0.91	9.20%
16	New Orleans	39	10.33	11.89	1.55	15.04%
17	Dallas	76	9.33	10.40	1.07	11.51%
17	San Antonio	28	9.96	11.31	1.35	13.54%
17	Temple (Waco)	71	9.00	9.30	0.30	3.37%
18	Albuquerque	67	10.28	10.31	0.02	0.24%
18	Phoenix	65	10.23	10.78	0.55	5.39%
19	Denver	72	8.88	9.59	0.72	8.08%
19	Fort Harrison	42	9.02	9.35	0.32	3.58%
19	Grand Junction	42	10.98	12.08	1.11	10.07%
19	Salt Lake City	62	9.76	10.73	0.98	10.00%
19	Sheridan	18	10.72	11.95	1.23	11.45%
19	Southern Colorado	75	10.21	11.10	0.88	8.66%
20	American Lake	45	9.11	9.35	0.24	2.65%
20	Boise	38	9.03	10.23	1.20	13.29%
20	Portland	45	10.09	11.22	1.14	11.25%
20	Seattle	57	9.72	10.21	0.49	5.03%
21	Palo Alto	61	8.97	8.85	-0.12	-1.30%
21	San Francisco	40	9.33	10.08	0.75	8.05%
22	Greater Los Angeles	55	9.11	10.08	0.97	10.65%
22	Long Beach	41	10.63	11.51	0.88	8.26%
22	San Diego	74	10.07	11.32	1.25	12.41%
23	Iowa City	47	10.47	11.62	1.16	11.05%
23	Knoxville	85	9.96	11.34	1.37	13.77%
23	Minneapolis	64	8.66	9.45	0.80	9.20%
23	Omaha	42	9.79	10.10	0.31	3.19%
23	St.Cloud	35	9.80	11.08	1.28	13.07%
ALL SITES		4506	9.64	10.36	0.79	8.15%
SITE AVERAGE		53.64	9.66	10.49	0.83	8.55%
SITE STD DEVIATION		25.47	0.61	0.82	0.44	4.48%

Change values are least squares means derived from analysis of covariance adjusted for site, time, baseline value, and eleven other baseline covariate

Shaded values represent significant t-test differences, in the undesired direction, between LS means for the indicated site and the median site on this variable.

Bold/Underlined values represent positive outliers.

Source: Client Interviews

TABLE 2-25. SATISFACTION WITH VA MHICM SERVICES

Pre-Entry vs. Follow-up

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
1	Bedford	133	3.08	3.81	0.74	24.03%
1	Brockton	53	3.08	3.63	0.55	17.98%
1	Togus	33	3.06	3.80	0.73	24.01%
1	West Haven	35	2.71	3.16	0.44	16.36%
2	Albany	30	3.17	3.76	0.59	18.77%
2	Buffalo	59	3.49	4.15	0.66	18.97%
2	Canandaigua	59	3.19	3.67	0.49	15.28%
2	Syracuse	43	3.19	3.83	0.64	20.13%
3	Brooklyn	55	2.85	3.39	0.54	18.75%
3	Hudson Valley	52	3.23	3.62	0.39	12.17%
3	New Jersey	87	3.10	3.60	0.49	15.87%
3	Northport	41	3.07	3.73	0.65	21.21%
4	Coatesville	101	3.14	3.67	0.53	16.92%
4	Lebanon	19	2.53	3.10	0.58	22.83%
4	Philadelphia	32	3.25	4.06	0.81	24.87%
4	Pittsburgh	122	3.12	3.81	0.69	22.08%
5	Baltimore	27	3.19	3.44	0.26	8.03%
5	Martinsburg	48	3.27	4.04	0.77	23.52%
5	Perry Point	54	3.37	3.81	0.44	12.95%
5	Washington, DC	47	2.79	3.13	0.34	12.28%
6	Fayetteville	34	2.71	3.20	0.49	18.15%
6	Hampton	40	3.13	3.97	0.85	27.05%
6	Salem	31	3.61	4.46	0.84	23.37%
6	Salisbury	51	3.41	4.19	0.78	22.76%
7	Atlanta	50	3.12	3.46	0.34	10.75%
7	Augusta	71	3.34	3.72	0.38	11.40%
7	Birmingham	32	3.00	3.03	0.03	0.90%
7	Charleston	33	3.18	3.89	0.70	22.14%
7	Columbia	43	3.37	3.88	0.50	14.93%
7	Tuscaloosa	51	3.29	3.81	0.51	15.53%
7	Tuskegee	53	3.40	4.06	0.67	19.63%
8	Gainesville	49	2.84	3.35	0.51	18.14%
8	Miami	48	3.19	3.76	0.57	18.03%
8	Tampa	21	3.62	3.76	0.14	3.94%
8	West Palm Beach	23	3.65	4.09	0.43	11.90%
10	Akron	42	3.17	3.76	0.60	18.82%
10	Chillicothe	85	3.07	3.71	0.64	20.69%
10	Cincinnati	133	3.47	4.00	0.53	15.22%
10	Cleveland	134	3.09	3.61	0.52	16.80%
10	Columbus	28	2.96	3.45	0.49	16.43%
10	Dayton	117	3.22	3.88	0.66	20.43%
10	Mansfield	36	3.44	3.93	0.48	14.07%
10	Youngstown	40	3.35	4.06	0.71	21.24%
11	Ann Arbor	45	2.96	3.55	0.59	20.11%
11	Battle Creek	69	3.06	3.58	0.52	17.08%
11	Danville	27	2.78	3.62	0.84	30.33%
11	Detroit	77	3.16	3.81	0.65	20.65%
11	Northern Indiana	42	2.79	3.34	0.56	19.98%
12	Chicago-West Side	58	3.52	4.26	0.74	21.18%
12	Madison	44	3.34	3.90	0.56	16.71%
12	Milwaukee	50	3.72	4.44	0.72	19.24%
12	North Chicago	124	3.17	3.73	0.56	17.57%

VISN	SITE	1 Pre-Entry N	2 Pre-Entry Mean	3 Follow-up Mean (2 + 4)	4 Change at Follow-up	5 Percent Change (4 / 2)
12	Tomah	27	3.52	4.33	0.82	23.20%
15	St. Louis	58	2.93	3.71	0.78	26.55%
15	Topeka	37	2.89	3.59	0.70	24.21%
16	Gulf Coast	51	3.00	3.69	0.69	22.99%
16	Houston	68	3.01	3.71	0.69	23.00%
16	Little Rock	49	3.16	3.22	0.06	1.87%
16	New Orleans	45	3.22	3.90	0.68	21.16%
17	Dallas	73	3.32	3.79	0.48	14.48%
17	San Antonio	32	3.03	3.63	0.60	19.66%
17	Temple (Waco)	69	3.35	3.74	0.39	11.67%
18	Albuquerque	70	3.17	3.60	0.43	13.47%
18	Phoenix	65	3.18	3.39	0.21	6.55%
19	Denver	70	2.93	3.38	0.45	15.30%
19	Fort Harrison	40	2.85	3.27	0.42	14.70%
19	Grand Junction	43	3.42	4.14	0.72	21.05%
19	Salt Lake City	65	3.15	3.79	0.64	20.30%
19	Sheridan	18	3.44	4.07	0.63	18.30%
19	Southern Colorado	82	3.17	3.83	0.66	20.86%
20	American Lake	47	3.15	3.60	0.45	14.39%
20	Boise	39	3.23	3.81	0.57	17.79%
20	Portland	51	2.94	3.30	0.36	12.11%
20	Seattle	54	3.26	3.65	0.39	11.91%
21	Palo Alto	68	2.50	2.78	0.28	11.03%
21	San Francisco	41	3.05	3.53	0.48	15.76%
22	Greater Los Angeles	57	2.96	3.62	0.65	21.94%
22	Long Beach	45	3.42	4.20	0.78	22.81%
22	San Diego	73	3.49	4.12	0.62	17.83%
23	Iowa City	48	3.27	3.88	0.61	18.53%
23	Knoxville	85	3.15	3.86	0.71	22.52%
23	Minneapolis	71	2.99	3.52	0.53	17.80%
23	Omaha	43	3.40	4.05	0.65	19.21%
23	St.Cloud	36	3.25	3.82	0.57	17.59%
ALL SITES		4631	3.16	3.74	0.56	17.83%
SITE AVERAGE		55.13	3.16	3.73	0.56	17.77%
SITE STD DEVIATION		26.20	0.24	0.32	0.17	5.31%

Change values are least squares means derived from analysis of covariance adjusted for site, time, baseline value, and eleven other baseline covariate

Shaded values represent significant t-test differences, in the undesired direction, between LS means for the indicated site and the median site on this variable.

Bold/Underlined values represent positive outliers.

Source: Client Interviews

TABLE 2-26. MHICM UNIT COSTS(Based on FY 2005 Expenditures)

VISN	SITE	FY 05 TOTAL EXPENDIT.	TOTAL VETS	COST PER VETERAN	FY 05 P/S EXPEND.	FY 05		ADJUSTED TOTAL VISITS PER VET/YR	TOTAL VISITS PER SITE/YR	COST PER VISIT
						FILLED	COST			
						FTE	PER FTE			
1	BEDFORD	1015282	142	\$7,150	988442	10.88	\$90,849	92.35	13114	\$77
1	BROCKTON	454404	80	\$5,680	454404	4.85	\$93,692	52.31	4185	\$109
1	TOGUS	359720	35	\$10,278	346345	4.6	\$75,292	62.18	2176	\$165
1	WEST HAVEN	562359	67	\$8,393	538941	5.83	\$92,443	78.85	5283	\$106
2	ALBANY	365349	54	\$6,766	365049.2	5.35	\$68,233	100.87	5447	\$67
2	BUFFALO	457736	92	\$4,975	445912	7.6	\$58,673	44.45	4090	\$112
2	CANANDAIGUA	690214	105	\$6,573	659676.1	9.55	\$69,076	94.43	9915	\$70
2	SYRACUSE	328734	51	\$6,446	328734	3.75	\$87,662	58.01	2958	\$111
3	BROOKLYN	418611	60	\$6,977	418611.4	4.4	\$95,139	37.58	2255	\$186
3	HUDSON VALLEY	914732	90	\$10,164	912474	8.5	\$107,350	68.79	6191	\$148
3	NEW JERSEY	808614	95	\$8,512	778239	7.9	\$98,511	56.65	5382	\$150
3	NORTHPORT	639732	114	\$5,612	603265.1	6.1	\$98,896	56.12	6397	\$100
4	COATESVILLE	455939	109	\$4,183	451673.7	6	\$75,279	73.62	8024	\$57
4	LEBANON	402284	20	\$20,114	380025	5	\$76,005	80.98	1620	\$248
4	PHILADELPHIA	415011	32	\$12,969	406611	3.7	\$109,895	109.37	3500	\$119
4	PITTSBURGH	891586	132	\$6,754	889806	9.1	\$97,781	40.06	5287	\$169
5	BALTIMORE	353918	28	\$12,640	345145.6	3.7	\$93,283	65.43	1832	\$193
5	MARTINSBURG	249083	49	\$5,083	249083	4	\$62,271	56.64	2775	\$90
5	PERRY POINT	457731	71	\$6,447	443769.5	5.6	\$79,245	70.37	4997	\$92
5	WASHINGTON, DC	379990	49	\$7,755	376340	6	\$62,723	70.83	3471	\$109
6	FAYETTEVILLE	336394	36	\$9,344	320609	4	\$80,152	65.44	2356	\$143
6	HAMPTON	411450	63	\$6,531	390720	5.3	\$73,721	89.91	5664	\$73
6	SALEM	262451	38	\$6,907	262451.1	2.5	\$104,980	53.32	2026	\$130
6	SALISBURY	431632	61	\$7,076	411632	4.7	\$87,581	48.71	2971	\$145
7	ATLANTA	772478	69	\$11,195	753702	9.2	\$81,924	84.51	5831	\$132
7	AUGUSTA	373018	78	\$4,782	371518	6.5	\$57,157	72.25	5636	\$66
7	BIRMINGHAM	251567	39	\$6,450	241803	4.02	\$60,150	98.26	3832	\$66
7	CHARLESTON	418233	35	\$11,950	406728	4.2	\$96,840	80.31	2811	\$149
7	COLUMBIA	327586	57	\$5,747	327350.2	4	\$81,838	50.22	2862	\$114
7	TUSCALOOSA	507967	74	\$6,864	485391	6.6	\$73,544	75.33	5575	\$91
7	TUSKEGEE	327550	61	\$5,370	301005.6	5	\$60,201	67.52	4119	\$80
8	GAINESVILLE	565065	57	\$9,913	507988.7	6.7	\$75,819	82.92	4726	\$120
8	MIAMI	433831	89	\$4,875	413789	5.25	\$78,817	67.54	6011	\$72
8	TAMPA	401713	55	\$7,304	388415	8	\$48,552	67.33	3703	\$108
8	WEST PALM BEACH	444247	25	\$17,770	433960.6	4.7	\$92,332	87.81	2195	\$202
10	AKRON	532222	44	\$12,096	519908	4.5	\$115,535	77.81	3424	\$155
10	CHILLICOTHE	729241	113	\$6,453	710030.3	9.1	\$78,025	63.12	7132	\$102
10	CINCINNATI	814913	147	\$5,544	719164	9.3	\$77,329	47.49	6981	\$117
10	CLEVELAND	1118442	146	\$7,661	1108876	14	\$79,205	72.24	10546	\$106
10	COLUMBUS	212099	29	\$7,314	198558.5	3.66	\$54,251	70.19	2036	\$104
10	DAYTON	724420	128	\$5,660	703462.6	9.7	\$72,522	57.52	7362	\$98
10	MANSFIELD	419544	38	\$11,041	408984	5.1	\$80,193	79.55	3023	\$139
10	YOUNGSTOWN	397649	44	\$9,037	385985	5.25	\$73,521	75.13	3306	\$120
11	ANN ARBOR	397927	54	\$7,369	355355	5.2	\$68,338	84.62	4570	\$87
11	BATTLE CREEK	439137	78	\$5,630	419639	6.2	\$67,684	61.86	4825	\$91
11	DANVILLE	280543	42	\$6,680	262201	4	\$65,550	131.20	5510	\$51
11	DETROIT	544750	88	\$6,190	538250	6.93	\$77,670	40.36	3552	\$153
11	NORTHERN INDIANA	629629	84	\$7,496	552079.8	6.9	\$80,012	83.24	6992	\$90
12	CHICAGO-WEST SIDE	449213	73	\$6,154	449212.9	6.25	\$71,874	73.42	5359	\$84
12	MADISON	476898	50	\$9,538	433258	4.63	\$93,576	155.76	7788	\$61
12	MILWAUKEE	438850	53	\$8,280	418903.5	4.45	\$94,136	64.65	3426	\$128

VISN	SITE	FY 05				ADJUSTED		TOTAL		COST PER VISIT
		FY 05 TOTAL EXPENDIT.	TOTAL VETS	COST PER VETERAN	FY 05 P/S EXPEND.	FY 05 FILLED FTE	COST PER FTE	TOTAL VISITS PER VET/YR	TOTAL VISITS PER SITE/YR	
12	NORTH CHICAGO	811946	135	\$6,014	792021	8.33	\$95,081	98.79	13336	\$61
12	TOMAH	243512	52	\$4,683	229451	2.81	\$81,655	129.02	6709	\$36
15	ST. LOUIS	385811	67	\$5,758	360508	5	\$72,102	49.18	3295	\$117
15	TOPEKA	517265	104	\$4,974	517265	8.3	\$62,321	126.42	13148	\$39
16	GULF COAST	330314	53	\$6,232	324605	5.7	\$56,948	55.53	2943	\$112
16	HOUSTON	487948	69	\$7,072	469783	4.1	\$114,581	51.68	3566	\$137
16	LITTLE ROCK	432624	58	\$7,459	423034	5	\$84,607	85.75	4974	\$87
16	NEW ORLEANS	405597	60	\$6,760	397012	4.88	\$81,355	42.07	2524	\$161
17	DALLAS	655502	81	\$8,093	644067	8	\$80,508	77.03	6240	\$105
17	SAN ANTONIO	355013	38	\$9,342	348013	3.5	\$99,432	87.39	3321	\$107
17	TEMPLE (WACO)	420495	73	\$5,760	401321	5	\$80,264	92.14	6726	\$63
18	ALBUQUERQUE	519948	73	\$7,123	491388	6.7	\$73,341	93.80	6847	\$76
18	PHOENIX	469922	103	\$4,562	446705	5.5	\$81,219	50.29	5180	\$91
19	DENVER	490587	77	\$6,371	489327	5.5	\$88,969	50.57	3894	\$126
19	FORT HARRISON	292912	51	\$5,743	292912.2	1	\$292,912	75.70	3860	\$76
19	GRAND JUNCTION	246963	45	\$5,488	242763	4	\$60,691	67.87	3054	\$81
19	SALT LAKE CITY	475519	71	\$6,697	463278	5.5	\$84,232	74.53	5292	\$90
19	SHERIDAN	231401	18	\$12,856	138378	1.5	\$92,252	47.18	849	\$272
19	SOUTHERN COLORADO	586792	93	\$6,310	493716	6.25	\$78,995	67.60	6287	\$93
20	AMERICAN LAKE	348324	54	\$6,450	347538.5	4.65	\$74,739	53.57	2893	\$120
20	BOISE	305304	40	\$7,633	297110.1	3.55	\$83,693	22.27	891	\$343
20	PORTLAND	683377	80	\$8,542	660898	7.5	\$88,120	83.20	6656	\$103
20	SEATTLE	348324	63	\$5,529	347538.5	4.1	\$84,765	50.31	3169	\$110
21	PALO ALTO	458456	73	\$6,280	450056	6.9	\$65,226	61.33	4477	\$102
21	SAN FRANCISCO	475649	46	\$10,340	450773	3.7	\$121,831	70.22	3230	\$147
22	GREATER LOS ANGELES	651117	69	\$9,436	626697.5	7	\$89,528	56.91	3927	\$166
22	LONG BEACH	358803	49	\$7,323	347253	4.25	\$81,707	88.42	4332	\$83
22	SAN DIEGO	467380	76	\$6,150	465380.1	5.7	\$81,646	61.14	4646	\$101
23	IOWA CITY	422091	52	\$8,117	368211	5.3	\$69,474	55.12	2866	\$147
23	KNOXVILLE	650351	90	\$7,226	591415	8.5	\$69,578	61.58	5542	\$117
23	MINNEAPOLIS	468255	72	\$6,504	468255.2	6.2	\$75,525	53.27	3836	\$122
23	OMAHA	388861	48	\$8,101	372486.7	5.11	\$72,894	56.59	2716	\$143
23	ST.CLOUD	288927	40	\$7,223	270070	3.1	\$87,119	42.47	1699	\$170
ALL SITES		\$40,166,977	5696	\$7,052	\$38,612,707	480.38	\$80,380	69.97	398,534	\$101
SITE AVERAGE		\$478,178.31	67.81	\$7,617	\$459,675	5.72	\$83,365	70.69	4,738	\$116
SITE STD. DEV.		\$179,964.04	29.20	\$2,662	\$176,238	2.11	\$27,123	22.25	2,484	\$48

* Expenditures include space rental.

~MHICM teams (N=8) with insufficient data to be included in this Report: Durham, Louisville, Memphis, Tennessee Valley, Indianapolis, Hines, Tucson, and Loma Linda. No signed reports from Ann Arbor and Palo Alto.

Cleveland data are aggregated for three teams.

Excludes veterans treated by MHICM staff but receiving non-MHICM services.

Source: MHICM Local Progress Reports FY 2005

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TABLE 2-27. SITE PERFORMANCE ON MHICM CRITICAL MONITORS

					Total Team	Total Applicable	%Outliers/ Applicable						Total Team	Total Applicable	%Outliers/ Applicable						
VISN	SITE	STRUCTURE	CLIENT	PROCESS	OUTCOME	Outliers	Monitors	Monitors	VISN	SITE	STRUCTURE	CLIENT	PROCESS	OUTCOME	Outliers	Monitors	Monitors				
1	Bedford	0	0	0	1	1	17	5.9%	11	Detroit	0	0	3	0	3	17	17.6%				
1	Brockton	3	0	0	0	3	17	17.6%	11	Northern Indiana	1	0	0	0	1	17	5.9%				
1	Togus	0	0	0	0	0	17	0.0%	12	Chicago-West Side	0	0	0	0	0	17	0.0%				
1	West Haven	1	0	0	0	1	17	5.9%	12	Madison	1	0	0	1	2	17	11.8%				
2	Albany	1	0	0	0	1	17	5.9%	12	Milwaukee	2	1	0	1	4	17	23.5%				
2	Buffalo	0	1	3	1	5	17	29.4%	12	North Chicago	2	0	1	0	3	17	17.6%				
2	Canandaigua	1	0	1	2	4	17	23.5%	12	Tomah	2	0	0	0	2	17	11.8%				
2	Syracuse	3	0	0	0	3	17	17.6%	15	St. Louis	3	0	3	0	6	17	35.3%				
3	Brooklyn	2	0	2	1	5	17	29.4%	15	Topeka	0	0	0	0	0	17	0.0%				
3	Hudson Valley	0	0	1	1	2	17	11.8%	16	Gulf Coast	0	0	1	0	1	17	5.9%				
3	New Jersey	1	0	0	0	1	17	5.9%	16	Houston	3	0	1	0	4	17	23.5%				
3	Northport	2	0	1	0	3	17	17.6%	16	Little Rock	0	0	0	1	1	17	5.9%				
4	Coatesville	2	0	2	0	4	17	23.5%	16	New Orleans	1	0	1	0	2	17	11.8%				
4	Lebanon	3	0	0	0	3	17	17.6%	17	Dallas	1	0	1	0	2	17	11.8%				
4	Philadelphia	2	0	1	0	3	17	17.6%	17	San Antonio	1	0	0	1	2	17	11.8%				
4	Pittsburgh	1	0	3	0	4	17	23.5%	17	Temple (Waco)	2	0	1	0	3	17	17.6%				
5	Baltimore	3	0	0	0	3	17	17.6%	18	Albuquerque	2	0	0	2	4	17	23.5%				
5	Martinsburg	2	0	0	1	3	17	17.6%	18	Phoenix	1	1	3	1	6	17	35.3%				
5	Perry Point	1	0	0	0	1	17	5.9%	19	Denver	1	0	1	0	2	17	11.8%				
5	Washington, DC	0	1	0	2	3	17	17.6%	19	Fort Harrison	3	0	2	1	6	17	35.3%				
6	Fayetteville	2	0	1	0	3	17	17.6%	19	Grand Junction	2	0	0	1	3	17	17.6%				
6	Hampton	0	0	0	0	0	17	0.0%	19	Salt Lake City	0	1	0	1	2	17	11.8%				
6	Salem	1	0	2	0	3	17	17.6%	19	Sheridan	2	0	1	2	5	17	29.4%				
6	Salisbury	0	0	1	2	3	17	17.6%	19	Southern Colorado	2	1	0	0	3	17	17.6%				
7	Atlanta	0	0	0	0	0	17	0.0%	20	American Lake	0	0	0	1	1	17	5.9%				
7	Augusta	1	0	0	0	1	17	5.9%	20	Boise	1	1	1	0	3	17	17.6%				
7	Birmingham	1	0	0	0	1	17	5.9%	20	Portland	0	0	0	0	0	17	0.0%				
7	Charleston	1	0	0	0	1	17	5.9%	20	Seattle	3	1	1	1	6	17	35.3%				
7	Columbia	2	1	2	0	5	17	29.4%	21	Palo Alto	2	0	0	0	2	17	11.8%				
7	Tuscaloosa	1	0	0	0	1	17	5.9%	21	San Francisco	1	0	0	0	1	17	5.9%				
7	Tuskegee	2	0	0	1	3	17	17.6%	22	Greater Los Angeles	1	0	0	2	3	17	17.6%				
8	Gainesville	0	0	0	0	0	17	0.0%	22	Long Beach	1	0	0	0	1	17	5.9%				
8	Miami	2	1	0	1	4	17	23.5%	22	San Diego	2	0	0	0	2	17	11.8%				
8	Tampa	2	1	1	1	5	17	29.4%	23	Iowa City	0	0	0	0	0	17	0.0%				
8	West Palm Beach	1	0	0	0	1	17	5.9%	23	Knoxville	0	0	0	0	0	17	0.0%				
10	Akron	2	0	1	3	6	17	35.3%	23	Minneapolis	0	0	1	1	2	17	11.8%				
10	Chillicothe	0	0	0	0	0	17	0.0%	23	Omaha	1	0	0	0	1	17	5.9%				
10	Cincinnati	1	1	1	0	3	17	17.6%	23	St.Cloud	2	0	1	0	3	17	17.6%				
10	Cleveland	0	0	2	0	2	17	11.8%	OUTLIER SITES(N)				60	13	36	30	74	1428	14.4%		
10	Columbus	2	0	0	1	3	17	17.6%	OUTLIER SITES(%)				71.4%	15.5%	42.9%	35.7%	88.1%				
10	Dayton	1	1	0	1	3	17	17.6%	OUTLIER TOTAL				100	13	53	39	205				
10	Mansfield	1	0	1	0	2	17	11.8%	TOTAL MONITORS				420	252	420	336	1428	1428			
10	Youngstown	0	0	1	0	1	17	5.9%	% OUTLIERS/TOTAL				23.8%	5.2%	12.6%	11.6%	14.4%				
11	Ann Arbor	1	0	0	0	1	17	5.9%	OUTLIER MEAN				1.19	0.15	0.63	0.46	2.44	17	14.4%		
11	Battle Creek	0	0	2	1	3	17	17.6%													
11	Danville	2	0	1	2	5	17	29.4%										95			

TABLE 2-28. OUTLIERS FOR TEAM STRUCTURE MONITORS

VISN	SITE	1 FTE UNFILLED MORE THAN 6 MONTHS (Y)	2 UNASSIGNED MEDICAL SUPPORT MD and/or RN (N)	3 CASELOAD SIZE MEAN RATIO OF CLIENTS PER CLINICAL FTEE (LT 7 or GT 15)	4 TEAM SIZE # FULL-TIME CLINICAL STAFF (4.0+ FTEE)	5 TOTAL TEAM STRUCTURE OUTLIERS (1+2+3+4)	6 # APPLICABLE TEAM STRUCTURE MONITORS (1+2+3+4)	7 % OUTLIERS/ APPLICABLE STRUCTURE MONITORS (5/6)
Outlier Direction								
1	Bedford					0	5	0%
1	Brockton		N	18.29		3	5	60%
1	Togus					0	5	0%
1	West Haven	Y				1	5	20%
2	Albany				3.75	1	5	20%
2	Buffalo					0	5	0%
2	Canandaigua		N			1	5	20%
2	Syracuse	Y		16.67	3.00	3	5	60%
3	Brooklyn		N		3.90	2	5	40%
3	Hudson Valley					0	5	0%
3	New Jersey		N			1	5	20%
3	Northport	Y	N			2	5	40%
4	Coatesville	Y		15.54		2	5	40%
4	Lebanon		N	5.71	3.50	3	5	60%
4	Philadelphia		N		2.75	2	5	40%
4	Pittsburgh			15.60		1	5	20%
5	Baltimore	Y		6.86	3.50	3	5	60%
5	Martinsburg		N		3.50	2	5	40%
5	Perry Point	Y				1	5	20%
5	Washington, DC	Y				0	5	0%
6	Fayetteville	Y			3.50	2	5	40%
6	Hampton					0	5	0%
6	Salem				1.50	1	5	20%
6	Salisbury					0	5	0%
7	Atlanta					0	5	0%
7	Augusta		N			1	5	20%
7	Birmingham				3.50	1	5	20%
7	Charleston				3.50	1	5	20%
7	Columbia		N		3.50	2	5	40%
7	Tuscaloosa	Y				1	5	20%
7	Tuskegee	Y	N			2	5	40%
8	Gainesville					0	5	0%
8	Miami			22.86	3.50	2	5	40%
8	Tampa		N	6.77		2	5	40%
8	West Palm Beach				3.00	1	5	20%
10	Akron	Y			3.50	2	5	40%
10	Chillicothe					0	5	0%
10	Cincinnati			15.76		1	5	20%
10	Cleveland					0	5	0%
10	Columbus		N		3.33	2	5	40%
10	Dayton		N			1	5	20%
10	Mansfield	Y				1	5	20%
10	Youngstown					0	5	0%
11	Ann Arbor				3.50	1	5	20%
11	Battle Creek					0	5	0%
11	Danville		N		3.50	2	5	40%
11	Detroit					0	5	0%
11	Northern Indiana		N			1	5	20%

VISN	SITE	1 FTE UNFILLED MORE THAN 6 MONTHS (Y)	2 UNASSIGNED MEDICAL SUPPORT MD and/or RN (N)	3 CASELOAD SIZE MEAN RATIO OF CLIENTS PER CLINICAL FTEE (LT 7 or GT 15)	4 TEAM SIZE # FULL-TIME CLINICAL STAFF (4.0+ FTEE)	5 TOTAL TEAM STRUCTURE OUTLIERS (1+2+3+4)	6 # APPLICABLE TEAM STRUCTURE MONITORS (1+2+3+4)	7 % OUTLIERS/ APPLICABLE STRUCTURE MONITORS (5/6)	
Outlier Direction									
12	Chicago-West Side					0	5	0%	
12	Madison				3.30	1	5	20%	
12	Milwaukee			17.33	3.00	2	5	40%	
12	North Chicago	Y		15.85		2	5	40%	
12	Tomah			18.67	2.25	2	5	40%	
15	St. Louis		N	16.86	3.50	3	5	60%	
15	Topeka					0	5	0%	
16	Gulf Coast					0	5	0%	
16	Houston	Y		15.71	3.50	3	5	60%	
16	Little Rock					0	5	0%	
16	New Orleans				3.50	1	5	20%	
17	Dallas		N			1	5	20%	
17	San Antonio				3.00	1	5	20%	
17	Temple (Waco)		N			2	5	40%	
18	Albuquerque		N	16.19		2	5	40%	
18	Phoenix		N			1	5	20%	
19	Denver		N			1	5	20%	
19	Fort Harrison		N	43.00	1.00	3	5	60%	
19	Grand Junction		N		3.50	2	5	40%	
19	Salt Lake City					0	5	0%	
19	Sheridan		N		1.20	2	5	40%	
19	Southern Colorado		N	15.45		2	5	40%	
20	American Lake					0	5	0%	
20	Boise				3.00	1	5	20%	
20	Portland					0	5	0%	
20	Seattle	Y		17.10	3.45	3	5	60%	
21	Palo Alto	Y			3.00	2	5	40%	
21	San Francisco				3.00	1	5	20%	
22	Greater Los Angeles		N			1	5	20%	
22	Long Beach				3.50	1	5	20%	
22	San Diego	Y		17.25		2	5	40%	
23	Iowa City					0	5	0%	
23	Knoxville					0	5	0%	
23	Minneapolis					0	5	0%	
23	Omaha				3.50	1	5	20%	
23	St.Cloud	Y			2.50	2	5	40%	
OUTLIER SITES (N)		17	27	2	19	35	60	420	24%
OUTLIER SITES (%)		20.2%	32.1%	2.4%	22.6%	41.7%	71.4%	100%	
OUTLIER TOTAL						100	420	24%	

Outlier: Significant difference (p<0.05) from median site in undesired direction, after adjusting for client differences and time in program.
[Team structure monitors are presented in Report Tables 2-5 (p.35) and 2-6(36).]

TABLE 2-29. OUTLIERS FOR CLIENT CHARACTERISTICS MONITORS

VISN	Outlier Direction	1 PERCENT OF CLIENTS WITH GTE 30 DAYS HOSP. YR PRE (LT 50%)	2 PERCENT OF CLIENTS WITH PSYCHOTIC DX AT ENTRY. (LT 50%)	3 MEAN GAF AT ENTRY EXCEEDS 50 (GT 50)	4 Total Client Outliers (1+2+3)	5 # Applicable Client Characteristic Monitors (1+2+3)	6 % Outliers/ Applicable Client Monitors (4/5)
1 Bedford					0	3	0%
1 Brockton					0	3	0%
1 Togus					0	3	0%
1 West Haven					0	3	0%
2 Albany					0	3	0%
2 Buffalo		33.9			1	3	33%
2 Canandaigua					0	3	0%
2 Syracuse					0	3	0%
3 Brooklyn					0	3	0%
3 Hudson Valley					0	3	0%
3 New Jersey					0	3	0%
3 Northport					0	3	0%
4 Coatesville					0	3	0%
4 Lebanon					0	3	0%
4 Philadelphia					0	3	0%
4 Pittsburgh					0	3	0%
5 Baltimore					0	3	0%
5 Martinsburg					0	3	0%
5 Perry Point					0	3	0%
5 Washington, DC		45.2			1	3	33%
6 Fayetteville					0	3	0%
6 Hampton					0	3	0%
6 Salem					0	3	0%
6 Salisbury					0	3	0%
7 Atlanta					0	3	0%
7 Augusta					0	3	0%
7 Birmingham					0	3	0%
7 Charleston					0	3	0%
7 Columbia		35.4			1	3	33%
7 Tuscaloosa					0	3	0%
7 Tuskegee					0	3	0%
8 Gainesville					0	3	0%
8 Miami		28.6			1	3	33%
8 Tampa				51.2	1	3	33%
8 West Palm Beach					0	3	0%
10 Akron					0	3	0%
10 Chillicothe					0	3	0%
10 Cincinnati		47.2			1	3	33%
10 Cleveland					0	3	0%
10 Columbus					0	3	0%
10 Dayton		29.3			1	3	33%
10 Mansfield					0	3	0%
10 Youngstown					0	3	0%
11 Ann Arbor					0	3	0%
11 Battle Creek					0	3	0%
11 Danville					0	3	0%
11 Detroit					0	3	0%
11 Northern Indiana					0	3	0%
12 Chicago-West Side					0	3	0%
12 Madison					0	3	0%

VISN	Outlier Direction	1 PERCENT OF CLIENTS WITH GTE 30 DAYS HOSP. YR PRE (LT 50%)	2 PERCENT OF CLIENTS WITH PSYCHOTIC DX AT ENTRY. (LT 50%)	3 MEAN GAF AT ENTRY EXCEEDS 50 (GT 50)	4 Total Client Outliers (1+2+3)	5 # Applicable Client Characteristic Monitors (1+2+3)	6 % Outliers/ Applicable Client Monitors (4/5)
12 Milwaukee		24.5			1	3	33%
12 North Chicago					0	3	0%
12 Tomah					0	3	0%
15 St. Louis					0	3	0%
15 Topeka					0	3	0%
16 Gulf Coast					0	3	0%
16 Houston					0	3	0%
16 Little Rock					0	3	0%
16 New Orleans					0	3	0%
17 Dallas					0	3	0%
17 San Antonio					0	3	0%
17 Temple (Waco)					0	3	0%
18 Albuquerque					0	3	0%
18 Phoenix		44.0			1	3	33%
19 Denver					0	3	0%
19 Fort Harrison					0	3	0%
19 Grand Junction					0	3	0%
19 Salt Lake City		43.9			1	3	33%
19 Sheridan					0	3	0%
19 Southern Colorado		22.5			1	3	33%
20 American Lake					0	3	0%
20 Boise		42.1			1	3	33%
20 Portland					0	3	0%
20 Seattle		28.3			1	3	33%
21 Palo Alto					0	3	0%
21 San Francisco					0	3	0%
22 Greater Los Angeles					0	3	0%
22 Long Beach					0	3	0%
22 San Diego					0	3	0%
23 Iowa City					0	3	0%
23 Knoxville					0	3	0%
23 Minneapolis					0	3	0%
23 Omaha					0	3	0%
23 St.Cloud					0	3	0%
OUTLIER SITES (N)		12	0	1	13	252	5%
OUTLIER SITES (%)		14.3%	0.0%	1.2%	15.5%	100%	
OUTLIER TOTAL					13	252	5%

[Client monitors are presented in Report Tables 2-10 and 2-11.]

TABLE 2-30. OUTLIERS FOR CLINICAL PROCESS MONITORS

VISN	SITE	1 Tenure % Clients Discharged (>20%)	2 Intensity % Clients Seen For GTE 1 Hour Per Week (≤1HR/WK)	3 Location % Clients Seen 60% Or More In Community (≤50%)	4 Frequency # Adjusted Face-Face Contacts/WK /Veteran (≤1/WK)	5 Team Provides Psychiatric Rehabilit'n Services (≤25% VETS)	6 Total Clinical Process Outliers (1+2+3+4+5)	7 # Applicable Clinical Process Outliers (1+2+3+4+5)	8 % Outliers/ Applicable Clinical Process Monitors (6/7)
1	Bedford						0	5	0%
1	Brockton						0	5	0%
1	Togus						0	5	0%
1	West Haven						0	5	0%
2	Albany						0	5	0%
2	Buffalo	23.9%	44.6		0.85		3	5	60%
2	Canandaigua	21.0%					1	5	20%
2	Syracuse						0	5	0%
3	Brooklyn	21.7%			0.72		2	5	40%
3	Hudson Valley		7.8				1	5	20%
3	New Jersey						0	5	0%
3	Northport	20.2%					1	5	20%
4	Coatesville	20.2%				20.3	2	5	40%
4	Lebanon						0	5	0%
4	Philadelphia					20.0	1	5	20%
4	Pittsburgh		29.5		0.77	23.4	3	5	60%
5	Baltimore						0	5	0%
5	Martinsburg						0	5	0%
5	Perry Point						0	5	0%
5	Washington, DC						0	5	0%
6	Fayetteville					24.1	1	5	20%
6	Hampton						0	5	0%
6	Salem	36.8%	47.4				2	5	40%
6	Salisbury				0.94		1	5	20%
7	Atlanta						0	5	0%
7	Augusta						0	5	0%
7	Birmingham						0	5	0%
7	Charleston						0	5	0%
7	Columbia				0.97	3.1	2	5	40%
7	Tuscaloosa						0	5	0%
7	Tuskegee						0	5	0%
8	Gainesville						0	5	0%
8	Miami						0	5	0%
8	Tampa					19.5	1	5	20%
8	West Palm Beach						0	5	0%
10	Akron		34.1				1	5	20%
10	Chillicothe						0	5	0%
10	Cincinnati				0.91		1	5	20%
10	Cleveland		40.4			24.5	2	5	40%
10	Columbus						0	5	0%
10	Dayton						0	5	0%
10	Mansfield					8.7	1	5	20%
10	Youngstown		40.9				1	5	20%
11	Ann Arbor						0	5	0%
11	Battle Creek	20.5%	34.6				2	5	40%
11	Danville	31.0%					1	5	20%
11	Detroit		35.2		0.78	5.1	3	5	60%
11	Northern Indiana						0	5	0%
12	Chicago-West Side						0	5	0%

VISN	SITE	1 Tenure % Clients Discharged	2 Intensity % Clients Seen For GTE 1 Hour Per Week	3 Location % Clients Seen 60% Or More In Community	4 Frequency # Adjusted Face-Face Contacts/WK /Veteran	5 Team Provides Psychiatric Rehabilit'n Services	6 Total Clinical Process Outliers (1+2+3+4+5)	7 # Applicable Clinical Process Outliers (1+2+3+4+5)	8 % Outliers/ Applicable Clinical Process Monitors (6/7)
Outlier Direction		(>20%)	(<1HR/WK)	(<50%)	(<1/WK)	(<25% VETS)			
12	Madison						0	5	0%
12	Milwaukee						0	5	0%
12	North Chicago	20.7%					1	5	20%
12	Tomah						0	5	0%
15	St. Louis		49.3		0.95	22.2	3	5	60%
15	Topeka						0	5	0%
16	Gulf Coast	22.6%					1	5	20%
16	Houston				0.99		1	5	20%
16	Little Rock						0	5	0%
16	New Orleans				0.81		1	5	20%
17	Dallas		27.2				1	5	20%
17	San Antonio						0	5	0%
17	Temple (Waco)					0.0	1	5	20%
18	Albuquerque						0	5	0%
18	Phoenix	27.2%			0.97	10.5	3	5	60%
19	Denver				0.97		1	5	20%
19	Fort Harrison		49.0			13.6	2	5	40%
19	Grand Junction						0	5	0%
19	Salt Lake City						0	5	0%
19	Sheridan				0.91		1	5	20%
19	Southern Colorado						0	5	0%
20	American Lake						0	5	0%
20	Boise				0.43		1	5	20%
20	Portland						0	5	0%
20	Seattle				0.97		1	5	20%
21	Palo Alto						0	5	0%
21	San Francisco						0	5	0%
22	Greater Los Angeles						0	5	0%
22	Long Beach						0	5	0%
22	San Diego						0	5	0%
23	Iowa City						0	5	0%
23	Knoxville						0	5	0%
23	Minneapolis		38.9				1	5	20%
23	Omaha						0	5	0%
23	St.Cloud				0.82		1	5	20%
OUTLIER SITES (N)		11	13	0	16	13	36	420	13%
OUTLIER SITES (%)		13%	15%	0%	19%	15%	43%	100%	
OUTLIER TOTAL							53	420	10%

[Clinical process monitors are presented in Report Tables 2-12, 2-13, 2-14, and 2-15.]

TABLE 2-31. OUTLIERS FOR CLIENT OUTCOME MONITORS

VISN	SITE	1 365 Days % Change MH Days (Post-Pre) (Low)	2 Reported Symptoms % Change (BSI) (HIGH)	3 Observed Symptoms % Change (BPRS) (HIGH)	4 Quality of Life % Change (QOL) (LOW)	5 Total Client Outcome Outliers (1+2+3+4)	6 # Applicable Client Outcome Monitors (1+2+3+4)	7 % Outliers/ Applicable Outcome Monitors (5/6)
Outlier Direction								
1	Bedford	-40.5%				1	4	25%
1	Brockton					0	4	0%
1	Togus					0	4	0%
1	West Haven					0	4	0%
2	Albany					0	4	0%
2	Buffalo	-22.4%				1	4	25%
2	Canandaigua		3.8%	5.8%		2	4	50%
2	Syracuse					0	4	0%
3	Brooklyn			3.7%		1	4	25%
3	Hudson Valley			3.4%		1	4	25%
3	New Jersey					0	4	0%
3	Northport					0	4	0%
4	Coatesville					0	4	0%
4	Lebanon					0	3	0%
4	Philadelphia					0	3	0%
4	Pittsburgh					0	4	0%
5	Baltimore					0	4	0%
5	Martinsburg	-42.1%				1	4	25%
5	Perry Point					0	4	0%
5	Washington, DC		5.7%	15.8%		2	4	50%
6	Fayetteville					0	4	0%
6	Hampton					0	4	0%
6	Salem					0	4	0%
6	Salisbury		17.7%	34.4%		2	4	50%
7	Atlanta					0	4	0%
7	Augusta					0	4	0%
7	Birmingham					0	4	0%
7	Charleston					0	4	0%
7	Columbia					0	4	0%
7	Tuscaloosa					0	4	0%
7	Tuskegee		6.6%			1	4	25%
8	Gainesville					0	4	0%
8	Miami	-48.0%				1	4	25%
8	Tampa			30.2%		1	4	25%
8	West Palm Beach					0	3	0%
10	Akron	-37.4%	3.1%	6.2%		3	4	75%
10	Chillicothe					0	4	0%
10	Cincinnati					0	4	0%
10	Cleveland					0	4	0%
10	Columbus			14.9%		1	4	25%
10	Dayton	-27.4%				1	4	25%
10	Mansfield					0	4	0%
10	Youngstown					0	4	0%
11	Ann Arbor					0	4	0%
11	Battle Creek				2.0%	1	4	25%
11	Danville	-34.1%	6.2%			2	4	50%
11	Detroit					0	4	0%
11	Northern Indiana					0	4	0%
12	Chicago-West Side					0	4	0%
12	Madison		-0.8%			1	4	25%
12	Milwaukee			5.2%		1	4	25%

VISN	SITE	1 365 Days % Change MH Days (Post-Pre) (Low)	2 Reported Symptoms % Change (BSI) (HIGH)	3 Observed Symptoms % Change (BPRS) (HIGH)	4 Quality of Life % Change (QOL) (LOW)	5 Total Client Outcome Outliers (1+2+3+4)	6 # Applicable Client Outcome Monitors (1+2+3+4)	7 % Outliers/ Applicable Outcome Monitors (5/6)
	Outlier Direction							
12	North Chicago					0	4	0%
12	Tomah					0	4	0%
15	St. Louis					0	4	0%
15	Topeka					0	4	0%
16	Gulf Coast					0	4	0%
16	Houston					0	4	0%
16	Little Rock	-20.4%				1	4	25%
16	New Orleans					0	4	0%
17	Dallas					0	4	0%
17	San Antonio		1.5%			1	4	25%
17	Temple (Waco)					0	4	0%
18	Albuquerque	-36.7%		1.0%		2	4	50%
18	Phoenix	-47.0%				1	4	25%
19	Denver					0	4	0%
19	Fort Harrison			7.8%		1	4	25%
19	Grand Junction	-38.8%				1	4	25%
19	Salt Lake City	-44.8%				1	4	25%
19	Sheridan		18.6%	23.5%		2	4	50%
19	Southern Colorado					0	4	0%
20	American Lake			7.5%		1	4	25%
20	Boise					0	4	0%
20	Portland					0	4	0%
20	Seattle			3.8%		1	4	25%
21	Palo Alto					0	4	0%
21	San Francisco					0	4	0%
22	Greater Los Angeles		2.2%	14.3%		2	4	50%
22	Long Beach					0	4	0%
22	San Diego					0	4	0%
23	Iowa City					0	4	0%
23	Knoxville					0	4	0%
23	Minneapolis			7.3%		1	4	25%
23	Omaha					0	4	0%
23	St.Cloud					0	4	0%
OUTLIER SITES (N)		12	10	16	1	30	333	9%
OUTLIER SITES (%)		14.3%	11.9%	19.0%	1.2%	46.4%	99.1%	46.8%
OUTLIER TOTAL						39	333	9%

[Client outcome monitors are presented in Report Tables 2-18a, 2-19, 2-20 and 2-23]

Note: There were two negative outliers for the IADL monitor. GAF and Satisfaction outcome monitors were excluded.

TABLE 2-32A. OUTLIERS FOR MINIMUM STANDARDS

VISN	SITE	1 % OF CLIENTS WITH PSYCHOTIC DX AT ENTRY	2 PERCENT OF CLIENTS WITH GTE 30 DAYS HOSP. PRIOR YR	3 # ADJUSTED FACE-FACE CONTACTS/WK/VETERAN	4 CASELOAD SIZE PER CLINICAL FTEE	5 % CLIENTS SEEN 60% OR MORE IN COMMUNITY	6 TEAM PROVIDES PSYCHIATRIC REHABILITAT'N SERVICES
Outlier Direction		(LT 50%)	(LT 50%)	(<1/WK)	7:1 TO 15:1	(<50%)	(<25%)
1	Bedford						
1	Brockton				18.3		
1	Togus						
1	West Haven						
2	Albany						
2	Buffalo		33.9	0.85			
2	Canandaigua						
2	Syracuse				16.7		
3	Brooklyn			0.72			
3	Hudson Valley						
3	New Jersey						
3	Northport						
4	Coatesville				15.5		20.3
4	Lebanon				5.7		
4	Philadelphia						20.0
4	Pittsburgh			0.77	15.6		23.4
5	Baltimore				6.9		
5	Martinsburg						
5	Perry Point						
5	Washington, DC		45.2				
6	Fayetteville						24.1
6	Hampton						
6	Salem						
6	Salisbury			0.94			
7	Atlanta						
7	Augusta						
7	Birmingham						
7	Charleston						
7	Columbia		35.4	0.97			3.1
7	Tuscaloosa						
7	Tuskegee						
8	Gainesville						
8	Miami		28.6		22.9		
8	Tampa				6.8		19.5
8	West Palm Beach						
10	Akron						
10	Chillicothe						
10	Cincinnati		47.2	0.91	15.8		
10	Cleveland						24.5
10	Columbus						
10	Dayton		29.3				
10	Mansfield						8.7
10	Youngstown						
11	Ann Arbor						
11	Battle Creek						
11	Danville						
11	Detroit			0.78			5.1

VISN	SITE	1 % OF CLIENTS WITH PSYCHOTIC DX AT ENTRY	2 PERCENT OF CLIENTS WITH GTE 30 DAYS HOSP. PRIOR YR	3 # ADJUSTED FACE-FACE CONTACTS/WK/VETERAN	4 CASELOAD SIZE PER CLINICAL FTEE	5 % CLIENTS SEEN 60% OR MORE IN COMMUNITY	6 TEAM PROVIDES PSYCHIATRIC REHABILITAT'N SERVICES
Outlier Direction		(LT 50%)	(LT 50%)	(<1/WK)	7:1 TO 15:1	(<50%)	(<25%)
11	Northern Indiana						
12	Chicago-West Side						
12	Madison						
12	Milwaukee		24.5		17.3		
12	North Chicago				15.9		
12	Tomah				18.7		
15	St. Louis			0.95	16.9		22.2
15	Topeka						
16	Gulf Coast						
16	Houston			0.99	15.7		
16	Little Rock						
16	New Orleans			0.81			
17	Dallas						
17	San Antonio						
17	Temple (Waco)						0.0
18	Albuquerque				16.2		
18	Phoenix		44.0	0.97			10.5
19	Denver			0.97			
19	Fort Harrison				43.0		13.6
19	Grand Junction						
19	Salt Lake City		43.9				
19	Sheridan			0.91			
19	Southern Colorado		22.5		15.4		
20	American Lake						
20	Boise		42.1	0.43			
20	Portland						
20	Seattle		28.3	0.97	17.1		
21	Palo Alto						
21	San Francisco						
22	Greater Los Angeles						
22	Long Beach						
22	San Diego				17.3		
23	Iowa City						
23	Knoxville						
23	Minneapolis						
23	Omaha						
23	St.Cloud			0.82			
<hr/>							
OUTLIER SITES (N)		0	12	16	19	0	13
OUTLIER SITES (%)		0.0%	14.3%	19.0%	22.6%	0.0%	15%
OUTLIER TOTAL							

[Clinical process monitors are presented in Report Tables 2-12, 2-13, 2-14, and 2-15.]

Minimum Program Standards are identified in the MHICM Directive and derived from FY 2001 monitors.

Shaded "outlier" values fall beneath threshold levels for the minimum program standard.

TABLE 2-32B. OUTLIERS FOR MINIMUM STANDARDS

VISN	SITE	7 TENURE % CLIENTS DISCHARGED	8 TEAM SIZE # FULL-TIME CLINICAL STAFF *	9 TOTAL MINIMUM PROGRAM STANDARDS OUTLIERS	10 % MINIMUM PROGRAM STANDARDS OUTLIERS	11 % MINIMUM PROGRAM STANDARDS OUTLIERS	12 CHANGE MINIMUM PROGRAM STANDARDS OUTLIERS
Outlier Direction		(>20%)	(4.0+FTTE	(Col. 1..8)	(Col. 9/8)	FY 2001	FY05-FY01
1	Bedford			0	0.0%	12.5%	-12.5%
1	Brockton			1	12.5%	25.0%	-12.5%
1	Togus			0	0.0%	25.0%	-25.0%
1	West Haven			0	0.0%	0.0%	0.0%
2	Albany		3.75	1	12.5%	37.5%	-25.0%
2	Buffalo	23.9%		3	37.5%	50.0%	-12.5%
2	Canandaigua	21.0%		1	12.5%	0.0%	12.5%
2	Syracuse		3.00	2	25.0%	50.0%	-25.0%
3	Brooklyn	21.7%	3.90	3	37.5%	12.5%	25.0%
3	Hudson Valley			0	0.0%		
3	New Jersey			0	0.0%	25.0%	-25.0%
3	Northport	20.2%		1	12.5%		
4	Coatesville	20.2%		3	37.5%	37.5%	0.0%
4	Lebanon		3.50	2	25.0%		
4	Philadelphia		2.75	2	25.0%		
4	Pittsburgh			3	37.5%	25.0%	12.5%
5	Baltimore		3.50	2	25.0%		
5	Martinsburg		3.50	1	12.5%		
5	Perry Point			0	0.0%	25.0%	-25.0%
5	Washington, DC			1	12.5%		
6	Fayetteville		3.50	2	25.0%		
6	Hampton			0	0.0%		
6	Salem	36.8%	1.50	2	25.0%		
6	Salisbury			1	12.5%	37.5%	-25.0%
7	Atlanta			0	0.0%	25.0%	-25.0%
7	Augusta			0	0.0%	0.0%	0.0%
7	Birmingham		3.50	1	12.5%		
7	Charleston		3.50	1	12.5%		
7	Columbia		3.50	4	50.0%		
7	Tuscaloosa			0	0.0%		
7	Tuskegee			0	0.0%	50.0%	-50.0%
8	Gainesville			0	0.0%	12.5%	-12.5%
8	Miami		3.50	3	37.5%		
8	Tampa			2	25.0%		
8	West Palm Beach		3.00	1	12.5%		
10	Akron		3.50	1	12.5%		
10	Chillicothe			0	0.0%	0.0%	0.0%
10	Cincinnati			3	37.5%	37.5%	0.0%
10	Cleveland			1	12.5%	12.5%	0.0%
10	Columbus		3.33	1	12.5%	37.5%	-25.0%
10	Dayton			1	12.5%	12.5%	0.0%
10	Mansfield			1	12.5%		
10	Youngstown			0	0.0%		
11	Ann Arbor		3.50	1	12.5%	12.5%	0.0%
11	Battle Creek	20.5%		1	12.5%	0.0%	12.5%
11	Danville	31.0%	3.50	2	25.0%		
11	Detroit			2	25.0%	12.5%	12.5%

VISN	SITE	7 TENURE % CLIENTS DISCHARGED	8 TEAM SIZE # FULL-TIME CLINICAL STAFF *	9 TOTAL MINIMUM PROGRAM STANDARDS OUTLIERS	10 % MINIMUM PROGRAM STANDARDS OUTLIERS	11 % MINIMUM PROGRAM STANDARDS OUTLIERS	12 CHANGE MINIMUM PROGRAM STANDARDS OUTLIERS
Outlier Direction		(>20%)	(4.0+FTEE	(Col. 1..8)	(Col. 9/8)	FY 2001	FY05-FY01
11	Northern Indiana			0	0.0%		
12	Chicago-West Side			0	0.0%		
12	Madison		3.30	1	12.5%	12.5%	0.0%
12	Milwaukee		3.00	3	37.5%		
12	North Chicago	20.7%		2	25.0%	12.5%	12.5%
12	Tomah		2.25	2	25.0%		
15	St. Louis		3.50	4	50.0%		
15	Topeka			0	0.0%		
16	Gulf Coast	22.6%		1	12.5%		
16	Houston		3.50	3	37.5%	12.5%	25.0%
16	Little Rock			0	0.0%	12.5%	-12.5%
16	New Orleans		3.50	2	25.0%		
17	Dallas			0	0.0%	25.0%	-25.0%
17	San Antonio		3.00	1	12.5%		
17	Temple (Waco)			1	12.5%		
18	Albuquerque			1	12.5%		
18	Phoenix	27.2%		4	50.0%		
19	Denver			1	12.5%	12.5%	0.0%
19	Fort Harrison		1.00	3	37.5%		
19	Grand Junction		3.50	1	12.5%	50.0%	-37.5%
19	Salt Lake City			1	12.5%	37.5%	-25.0%
19	Sheridan		1.20	2	25.0%		
19	Southern Colorado			2	25.0%	50.0%	-25.0%
20	American Lake			0	0.0%	0.0%	0.0%
20	Boise		3.00	3	37.5%	12.5%	25.0%
20	Portland			0	0.0%	0.0%	0.0%
20	Seattle		3.45	4	50.0%	12.5%	37.5%
21	Palo Alto		3.00	1	12.5%		
21	San Francisco		3.00	1	12.5%	25.0%	-12.5%
22	Greater Los Angeles			0	0.0%	37.5%	-37.5%
22	Long Beach		3.50	1	12.5%		
22	San Diego			1	12.5%		
23	Iowa City			0	0.0%		
23	Knoxville			0	0.0%	12.5%	-12.5%
23	Minneapolis			0	0.0%	25.0%	-25.0%
23	Omaha		3.50	1	12.5%		
23	St.Cloud		2.50	2	25.0%		
OUTLIER SITES (N)		11	35	59	16%	22%	-8%
OUTLIER SITES (%)		13%	42%	70%			
OUTLIER TOTAL				106			

* Staffing standard includes clinical case managers providing community-based services.

Table 2-33. SITE OUTLIER REVIEW SUMMARY

VISN	SITE	Site # of Outliers 2005 Total #	Reason A Legitimate differences not conflict with national goals	Reason B Local Policies may conflict with national goals	Reason C Implementation problems: Corrective action taken	Reason D Implementation problems: Corrective action planned	Reason E Implementation problems: No corrective action planned	Sum of Responses Reason A-E Total
			# of A's	# of B's	# of C's	# of D's	# of E's	
1	BEDFORD	1	1	0	0	0	0	1
1	BROCKTON	3	0	0	2	0	1	3
1	TOGUS	0	0	0	0	0	0	0
1	WEST HAVEN	1	1	0	0	0	0	1
2	ALBANY	1	0	0	0	1	0	1
2	BUFFALO	5	0	2	3	0	0	5
2	CANANDAIGUA	4	1	0	2	0	1	4
2	SYRACUSE	3	0	0	1	0	2	3
3	BROOKLYN	5	2	0	2	0	1	5
3	HUDSON VALLEY	2	0	0	1	1	0	2
3	NEW JERSEY	1	1	0	0	0	0	1
3	NORTHPORT	3	3	0	0	0	0	3
4	COATESVILLE	4	1	0	1	2	0	4
4	LEBANON	3	3	0	0	0	0	3
4	PHILADELPHIA	3	0	0	3	0	0	3
4	PITTSBURGH	4	3	0	1	0	0	4
5	BALTIMORE	3	1	2	0	0	0	3
5	MARTINSBURG	3	1	0	0	0	2	3
5	PERRY POINT	1	0	1	0	0	0	1
5	WASHINGTON, DC	3	0	0	0	3	0	3
6	FAYETTEVILLE	3	2	0	1	0	0	3
6	HAMPTON	0	0	0	0	0	0	0
6	SALEM	3	0	0	2	1	0	3
6	SALISBURY	3	0	0	3	0	0	3
7	ATLANTA	0	0	0	0	0	0	0
7	AUGUSTA	1	1	0	0	0	0	1
7	BIRMINGHAM	1	0	0	0	1	0	1
7	CHARLESTON	1	0	0	1	0	0	1
7	COLUMBIA	5	0	0	0	5	0	5
7	TUSCALOOSA	1	1	0	0	0	0	1
7	TUSKEGEE	3	0	0	2	1	0	3
8	GAINESVILLE	0	0	0	0	0	0	0
8	MIAMI	4	1	0	3	0	0	4
8	TAMPA	5	1	0	3	1	0	5
8	WEST PALM BEACH	1	0	0	0	1	0	1
10	AKRON	6	6	0	0	0	0	6
10	CHILLICOTHE	0	0	0	0	0	0	0
10	CINCINNATI	3	1	2	0	0	0	3
10	CLEVELAND	2	2	0	0	0	0	2
10	COLUMBUS	3	1	1	1	0	0	3
10	DAYTON	3	0	3	0	0	0	3
10	MANSFIELD	2	1	0	1	0	0	2
10	YOUNGSTOWN	1	1	0	0	0	0	1
11	ANN ARBOR	1	0	0	1	0	0	1
11	BATTLE CREEK	3	0	0	0	3	0	3
11	DANVILLE	5	2	0	0	3	0	5
11	DETROIT	3	0	1	1	0	1	3
11	NORTHERN INDIANA	1	0	0	1	0	0	1
12	CHICAGO-WEST SIDE	0	0	0	0	0	0	0
12	MADISON	2	0	1	0	0	1	2
12	MILWAUKEE	4	0	3	1	0	0	4
12	NORTH CHICAGO	3	1	0	2	0	0	3
12	TOMAH	2	0	1	1	0	0	2
15	ST. LOUIS	6	1	1	2	1	1	6

Table 2-33. SITE OUTLIER REVIEW SUMMARY

VISN	SITE	Site # of Outliers 2005 Total #	Reason A Legitimate differences not conflict with national goals	Reason B Local Policies may conflict with national goals	Reason C Implementation problems: Corrective action taken	Reason D Implementation problems: Corrective action planned	Reason E Implementation problems: No corrective action planned	Sum of Responses Reason A-E Total
			# of A's	# of B's	# of C's	# of D's	# of E's	
15	TOPEKA	0	0	0	0	0	0	0
16	GULF COAST	1	1	0	0	0	0	1
16	HOUSTON	4	0	0	4	0	0	4
16	LITTLE ROCK	1	1	0	0	0	0	1
16	NEW ORLEANS	2	2	0	0	0	0	2
17	DALLAS	2	0	0	2	0	0	2
17	SAN ANTONIO	2	0	0	0	1	1	2
17	TEMPLE (WACO)	3	0	0	2	1	0	3
18	ALBUQUERQUE	4	0	0	1	3	0	4
18	PHOENIX	6	5	0	0	1	0	6
19	DENVER	2	1	0	0	1	0	2
19	FORT HARRISON	6	4	0	1	1	0	6
19	GRAND JUNCTION	3	1	2	0	0	0	3
19	SALT LAKE CITY	2	2	0	0	0	0	2
19	SHERIDAN	5	2	1	0	2	0	5
19	SOUTHERN COLORADO	3	0	1	1	1	0	3
20	AMERICAN LAKE	1	0	0	1	0	0	1
20	BOISE	3	3	0	0	0	0	3
20	PORTLAND	0	0	0	0	0	0	0
20	SEATTLE	6	1	2	0	0	3	6
21	PALO ALTO	2	0	0	2	0	0	2
21	SAN FRANCISCO	1	0	1	0	0	0	1
22	GREATER LOS ANGELES	3	3	0	0	0	0	3
22	LONG BEACH	1	0	0	1	0	0	1
22	SAN DIEGO	2	0	0	1	1	0	2
23	IOWA CITY	0	0	0	0	0	0	0
23	KNOXVILLE	0	0	0	0	0	0	0
23	MINNEAPOLIS	2	0	1	1	0	0	2
23	OMAHA	1	1	0	0	0	0	1
23	ST.CLOUD	3	0	2	1	0	0	3
<hr/>								
	OUTLIER SITES (N)	84	38	18	37	22	10	74
	OUTLIER SITES (%)	100.0%	45.2%	21.4%	44.0%	26.2%	11.9%	100.0%
	OUTLIER RESPONSES (N)	205	67	28	60	36	14	205
	OUTLIER RESPONSES (%)	100%	32.7%	13.7%	29.3%	17.6%	6.8%	100.0%

Source: MHICM Outlier Review, FY 2004

+ No Outliers

Figure 2-1. Travel Distance from MHICM offices to veteran residence.
Percent of veterans with case manager reported follow-up data N=4,202).

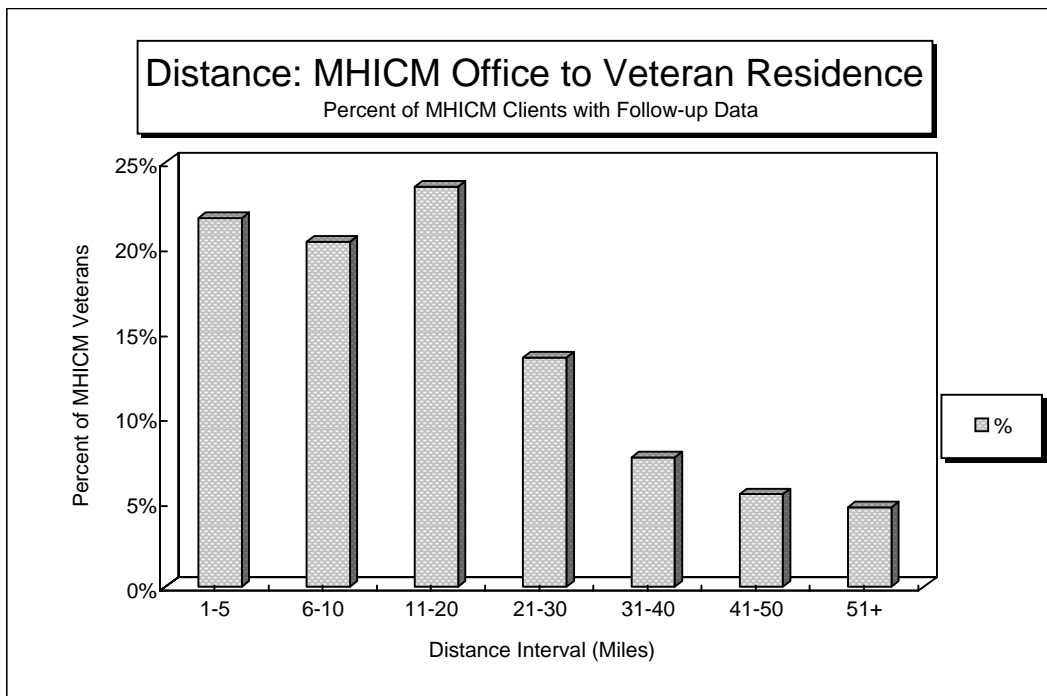


Figure 2-2. Travel Time from MHICM offices to veteran residence.
Percent of veterans with case manager reported follow-up data (N=4,162).

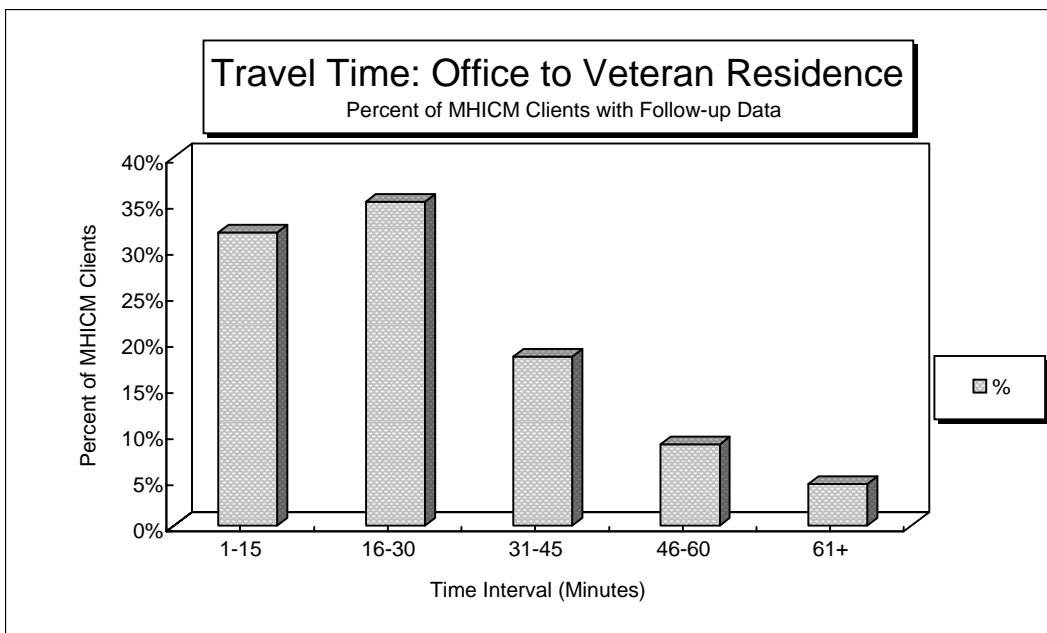


Figure 2-3. MHICM clients reporting expression of violence or criminal justice involvement.
Percent at entry (N=4,936) vs. Follow-up (N=3,402).

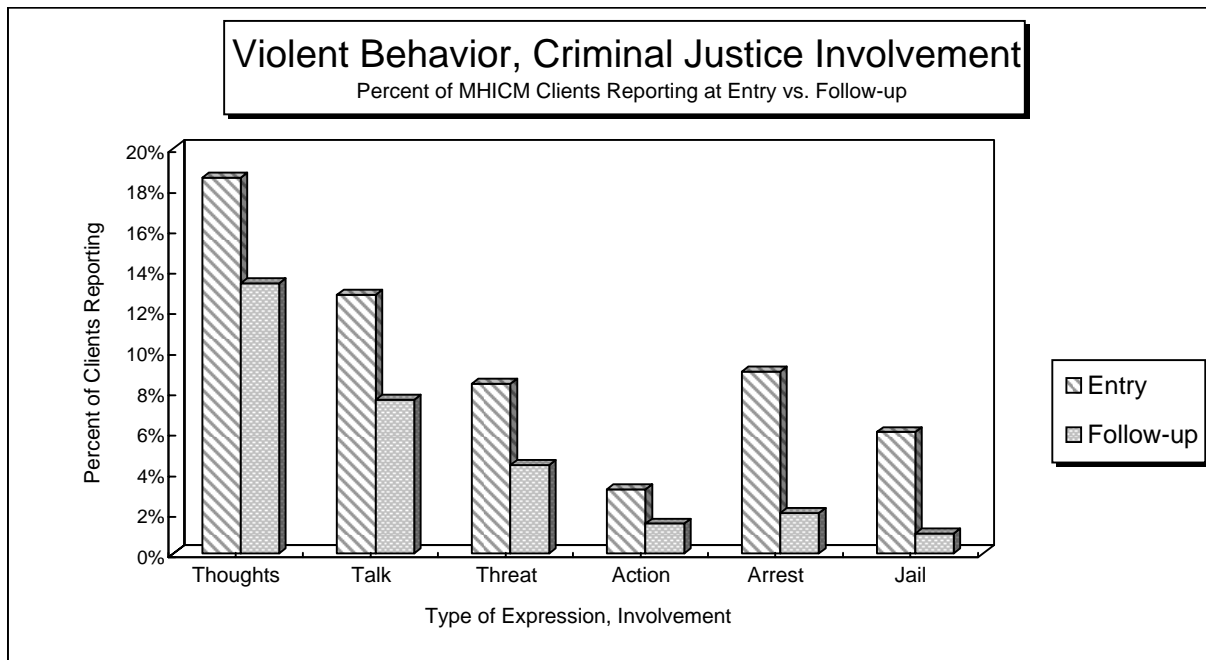


Figure 2-4. MHICM clients reporting expression of suicidality, hospitalization.
Percent at entry (N=4,884) vs. Follow-up (N=3,319).

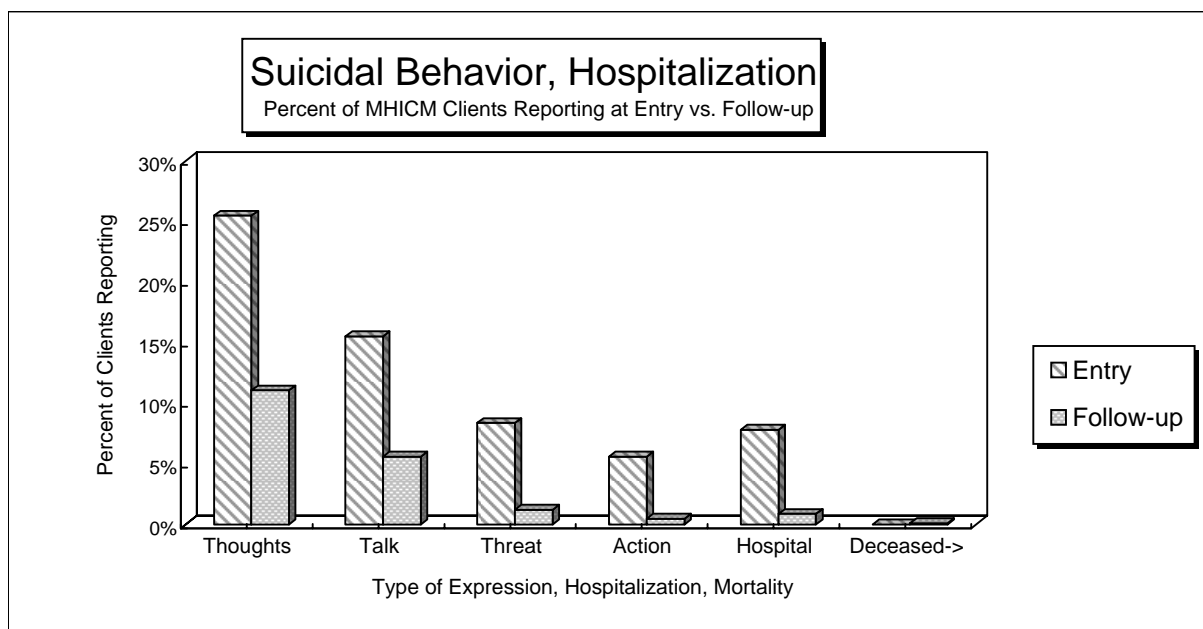


Figure 2-5. MHICM clients reporting living arrangements by level of independence.
Percent at entry (N=4,928) vs. follow-up (N=3,418).

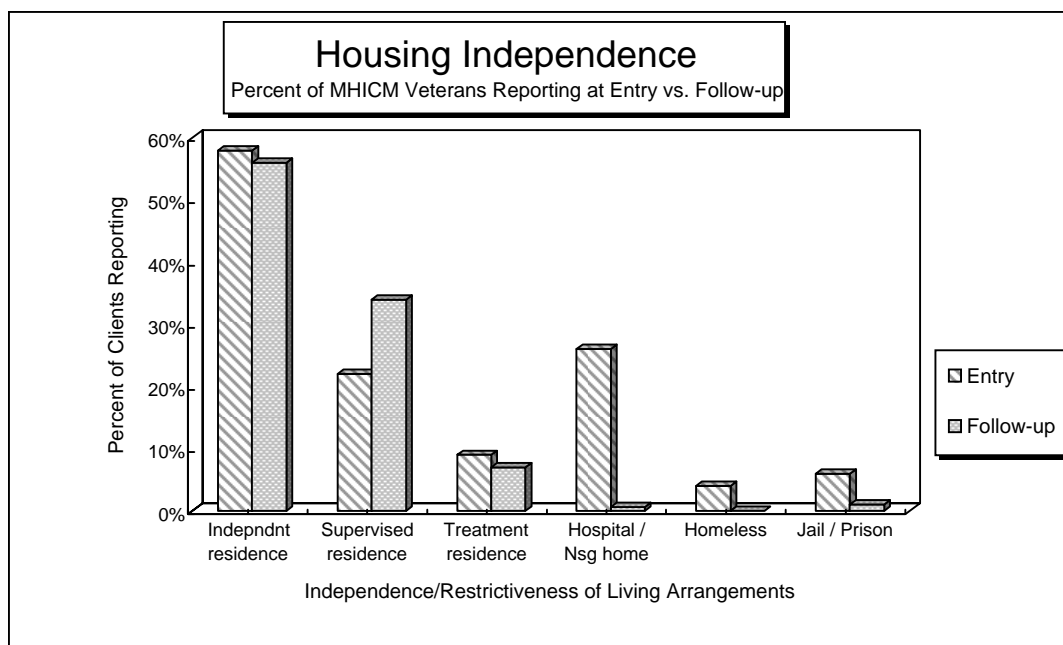
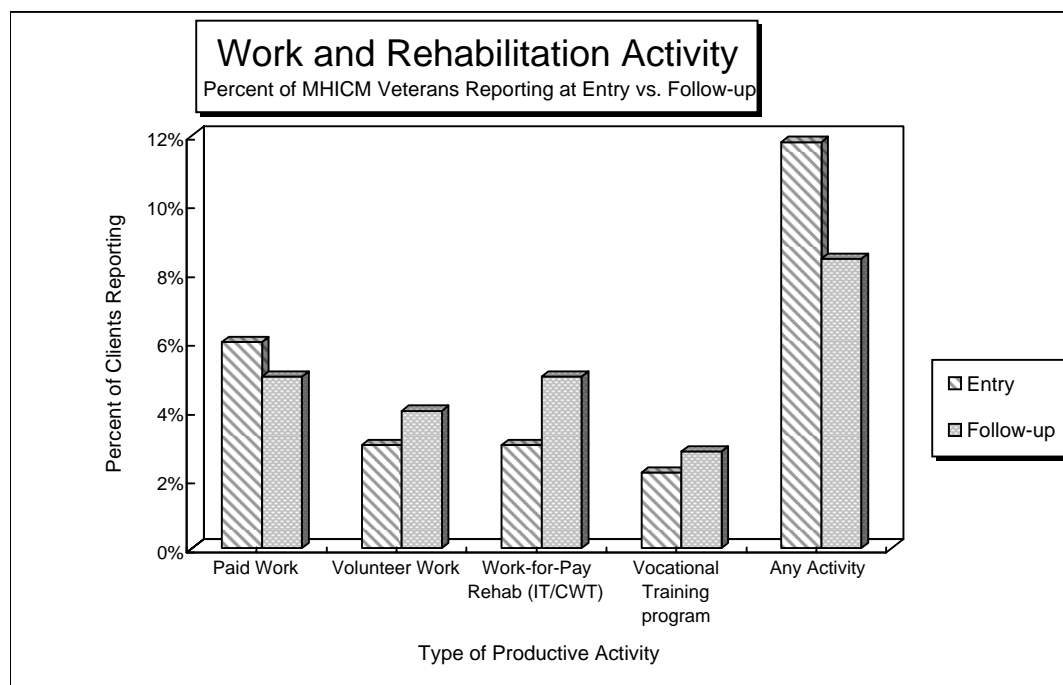


Figure 2-6. MHICM clients reporting participation in productive activity.
Percent at entry (N=4,946) vs. follow-up (N=3,437).



Appendices

- Appendix A. VHA Directive 2006-004 (“MHICM Directive”)
- Appendix B. MHICM Planning Material & Checklists
- Appendix C. Outlier Review Request and Form
- Appendix D. Legend for MHICM Performance Report Tables
- Appendix E. MHICM Case Management Services, FY 2004 (Registered Veterans)
- Appendix F. Non-MHICM Case Management Services, FY 2004
- Appendix G. MHICM Complex VERA Veterans, FY 2004
- Appendix H. MHICM Program Monitor Trends, FY 1997 – 2004.

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January 30, 2006

VHA MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM)

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy regarding VHA's mental health intensive case management (MHICM) program for seriously mentally ill veterans, a part of the mental health continuum of care.

2. BACKGROUND

a. Severe mental illness, primarily psychosis, is a major problem among veterans. Fiscal Year (FY) 2004 Compensation and Pension (C&P) data indicate that 108,226 veterans are service connected for psychoses of which 56,773 used VHA services. According to the Department of Veterans Affairs (VA) National Psychosis Registry, over 217,760 veterans diagnosed with a psychosis used VHA services in FY 2004. The clinical literature suggests that approximately 20 percent of people with severe mental illness are in need of intensive community case management services. Data from State mental health agencies suggest that nationally 4.5 percent currently receive Assertive Community Treatment (ACT), the most well-known approach to providing intensive case management.

(1) This intensive interdisciplinary team approach to ambulatory management and treatment of persons in, and coordinated with, the community and its services, is clearly distinguished from usual case management by:

- (a) Engagement in community settings of people with severe functional impairments traditionally managed in hospitals;
- (b) An unusually high staff to client ratio; multiple visits per week if needed;
- (c) Interventions primarily in the community rather than in office settings; and
- (d) Fixed team responsibility, around the clock, for total client care over a prolonged period (see subpar. 2e(2)).

(2) Multiple studies, including three recent VHA studies, have shown that the intervention is cost effective, particularly where the service is offered to chronically ill, hospitalized patients and where the model is rigorously adhered to with respect to assertiveness of the intervention and maintenance of low caseloads. There is compelling evidence for the effectiveness of ACT with clients who experience psychotic symptoms, but its use may also be considered in severe and persistent affective disorder, post-traumatic stress disorder (PTSD), etc., where independent functioning is impaired. However, a FY 1998 survey by the Committee on Care of Severely Chronically Mentally Ill (SCMI) Veterans revealed that just over 8,000 veterans received some form of mental health team case management from VHA, and of those, only 2,000 met ACT

THIS VHA DIRECTIVE EXPIRES JANUARY 31, 2011

Fidelity Measures criteria for intensive case management. Therefore, a gap in these state-of-the-art services is evident, resulting in unnecessary costs and patient morbidity to VHA.

b. The SCMI Strategic Implementation Committee considered various models of intensive case management within the mental health service arena, then defined intensive case management for veterans with severe mental illness in VHA and the accountability expected from this designated program.

c. Following issuance of VHA Directive 2000-034, VHA Mental Health Intensive Case Management (MHICM) a network planning process was initiated by NEPEC to stimulate implementation of MHICM services and monitoring of network implementation. NEPEC has produced quarterly reports to VA Central Office and to the Veterans Integrated Services Network (VISN) Directors along with a comprehensive annual report which documents adherence of each program to VHA policy, identifies outliers, and documents clinical outcomes using standardized measures.

d. MHICM is a cost-effective intervention given appropriate client selection in spite of the known resource intensity of the interventions. This efficiency (offset) results from avoidance of other costly interventions, such as: multiple or lengthy hospitalizations, extensive ambulatory clinic use, and visits to emergency rooms. **NOTE:** *Existing resources that previously supported inpatient care need to be shifted to support outpatient mental health services that foster a recovery process, such as MHICM teams.*

e. **Definitions**

(1) **Target Population.** MHICM programs are intended to provide necessary treatment and support for veterans who meet all of the following five criteria:

(a) **Diagnosis of Severe and Persistent Mental Illness.** Diagnosis of severe and persistent mental illness includes, but is not limited to: schizophrenia, bipolar disorder, major affective disorder, or severe PTSD. Mild to moderate organicity may coexist. Although the veteran may have a co-occurring alcohol or substance abuse diagnosis, this is not the primary problem for which treatment is required.

(b) **Severe Functional Impairment.** Severe functional impairment is such that the veteran is neither currently capable of successful and stable self-maintenance in a community living situation (e.g., hospitalized or homeless), nor able to participate in necessary treatments without intensive support. A Global Assessment of Functioning of 50 or less may be used to estimate the degree of impairment.

(c) **Inadequately Served.** The veteran is inadequately served by conventional clinic-based outpatient treatment or day treatment.

(d) **High Hospital Use.** High hospital use as evidenced during the past year by over 30 days of psychiatric hospital care, or three or more episodes of psychiatric hospitalization.

(e) Clinically Appropriate for Outpatient Status. Patients who are more appropriately managed clinically as inpatients need to remain in the inpatient setting; that is, the positive aspects of MHICM should not be used to justify moving veterans who would be better served by inpatient care to this ambulatory care model.

(2) **Description of the Program.** MHICM programs are delivered by an integrated, interdisciplinary team and are based on the Substance Abuse Mental Health Services Administration (SAMHSA) ACT standards. There are four core treatment elements:

(a) Very Frequent Contacts between Care Givers and Veteran Clients. The treatment process includes two phases:

1. High intensity of care (typically two to three contacts per week) primarily through home and community visits, with low caseloads (seven to fifteen veterans per 1.0 clinical Full-time Equivalent (FTE) employee), allowing rapid attention to crisis, and the development of community-living skills to prevent crisis in this exceptionally vulnerable population.

2. Appropriate transition to lower intensity care. After one year of MHICM treatment, some veteran clients can be transferred to either standard care or to continuous treatment by the MHICM team at a lower level of intensity (e.g., typically requiring community contacts less than once per week). Characteristics of readiness for a lower-level of care include the following, clients are:

- a. Clinically stable;
- b. Not abusing addictive substances;
- c. Not relying on extensive inpatient or emergency services;
- d. Capable of maintaining themselves in a community living situation; and

e. Independently participating in necessary treatments. **NOTE:** *NEPEC monitors this transition through periodic clinical progress reports and reports both levels of intensity separately. No more than 20 percent of a MHICM team caseload should consist of clients receiving "low intensity care."*

(b) Flexibility and Community Orientation. Flexibility and community orientation with most services provided in community settings and involving integration with natural support systems whenever possible (e.g., family members, landlord, employer).

(c) Focus on Rehabilitation. The focus on rehabilitation is through practical problem solving, crisis resolution, adaptive skill building, and transition to self-care, independent living, and competitive employment where possible.

(d) Responsibility. Identification of the team as a "fixed point of clinical responsibility" providing continuity of care for each veteran, wherever the veteran happens to be, for a prolonged

period. This responsibility is expected to last for a minimum of 1 year for all MHICM clients, but is subsequently based on a periodic review of continuing need for intensive services.

(3) Data Recording

(a) Decision Support System (DSS) Identifiers. Attachment A contains the definitions of the revised DSS Identifiers for the MHICM workload (546, 552, and 567) as well as the new code for general (non-intensive) mental health case management (564).

(b) The Office of Mental Health Services continues to work with the Office of Quality and Performance to develop performance indicators which may be used in the Executive Career Field (ECF) Performance Contract, such as the MHICM Capacity and Screening for MHICM in the FY 2005 contract.

(c) NEPEC continues to summarize, on a quarterly basis, data for each VISN indicating the ratio of MHICM-treated patients to those potentially eligible. **NOTE:** *VISNs may use these data to identify potential service gaps.*

3. POLICY: It is VHA policy to support the development of case management approaches sufficient to meet the need where appropriate; and MHICM programs need to be established out of existing or supplemental funds. **NOTE:** *NEPEC, which has developed and evaluated this type of program for 18 years, is providing the leadership for training and monitoring of new and established teams.*

4. ACTION

a. VISN Director. Each VISN Director is responsible for:

- (1) Addressing population-based needs for MHICM services;
- (2) Establishing strategies to provide their severely mentally ill veterans within the described target population (see subpar. 2e(1)) access to MHICM services sufficient to meet the need; and
- (3) Supporting recommendations by NEPEC to maintain MHICM standards.

b. Office of Mental Health Services. The Office of Mental Health Services is responsible for:

- (1) Assessing, deploying, evaluating, and disseminating quality and cost efficient best practices by utilizing NEPEC, Management Sciences Group, and Allocation Resource Center data and expertise and by collaborating with the Office of Quality and Performance (10Q).
- (2) Overseeing the effectiveness of the MHICM program by monitoring, training, and evaluating, and by collaborating with the SCMI Committee to assess clinical and deployment outcomes and to recommend future actions.

(3) Ensuring completion, quality, and distribution of MHICM monitoring reports and the Annual National MHICM Performance Monitoring Report.

(4) Recommending to the Office of the Deputy Under Secretary for Health for Operations and Management (10N) any MHICM program that should be dropped from the MHICM program because of persistent inability to meet evidence-based fidelity standards or reporting requirements.

c. **NEPEC.** NEPEC is responsible for:

(1) **Monitoring and Training Actions.** Because MHICM is resource intensive and the participating veterans are vulnerable, the following monitoring procedures will be implemented under the leadership of NEPEC. **NOTE:** *Forms may be obtained at <http://vhaaacweb3.vha.med.va.gov/NEPEC/Main.asp> . Questions may be addressed to (203) 937-3850.*

(a) **Standard Intake Data Form (IDF).** Standard IDF is administered to all new admissions to MHICM. It documents adherence to the eligibility criteria and records baseline data on clinical status, functional impairment, and satisfaction with services. The IDF takes about 30 to 45 minutes to complete per veteran.

(b) **Follow-up Data Form (FDF).** Follow-up FDF must be administered at 6 months and at 1 year after program entry and annually thereafter. It consists of a subset of health status and community adjustment measures from IDF. The FDF takes about 25 to 30 minutes to complete per veteran.

(c) **Clinical Process Form (CPF).** A CPF documents delivery of MHICM service elements and must be completed by each client's primary case manager every 6 months after program entry. The CPF takes about 15 minutes to complete on each veteran.

(d) **MHICM Check List and ACT Fidelity Measure.** The MHICM Check List and ACT Fidelity Measure are to be completed by the program director once a year for the entire program. This form takes about 20 minutes to complete.

(e) **MHICM Team Annual Report.** Each team must provide monthly data on staffing and clients. At the end of the fiscal year, teams must summarize data for the preceding year in the form of an annual report, due on November 15th of each year. Data from team reports and checklists (see subpar. 4b(4)) are integrated by NEPEC in the National MHICM Performance Monitoring Report. The MHICM Team Annual Report is distributed VHA and VISN Directors, VHA and VISN Chief Medical Officers, VHA and VISN QMO Peers, and Mental Health Service Line Leaders. In addition, it is available on the NEPEC website at: <http://vaww.nepec.mentalhealth.med.va.gov> .

(f) **VHA Administrative Data.** VHA administrative data are used to track MHICM process and outcomes using inpatient and outpatient service utilization data available from the Patient Treatment File and the Outpatient Care File in the Austin Automation Center.

(2) **Oversight.** Oversight is provided to all MHICM programs to ensure that standards are met through periodic site visits to treatment teams, regular national meetings of team leaders, conference calls, consultation, and national training programs. Programs systematically not meeting standards may be decertified from using the MHICM DSS Identifiers, after consultation with MSHSG.

(3) **Integration.** Data collection must be integrated into standard VA computerized data systems, providing sites with spreadsheet summaries of national and site-by-site program results on a regular basis, and providing clinicians with client-specific output for clinical review.

(4) **Reports**

(a) Periodic annual reports on the structure, process, and outcomes of MHICM services must be produced for training programs in evaluation and clinical procedures. These are available in bound version as well as electronic files and available for download on the NEPEC Intranet (<http://vaww.nepec.mentalhealth.med.va.gov>) and Internet (<http://www.nepec.org>) webpages.

(b) Reports on VISN-level population-based needs for which it is necessary to work with the Office of the Assistant Deputy Under Secretary for Health and the Serious Mental Illness Treatment, Research, and Evaluation Center (SMITREC).

(5) **Communication.** Facilitating ongoing communication and linkage among programs across the country is facilitated through monthly conference calls and up-to-date email groups.

(a) VISN and VA facility-level leadership must be informed where standards are problematic and there is a need to recommend actions to strengthen the MHICM teams.

(b) MSHSG leadership must be informed of MHICM programs that are persistently unable to meet the evidence-based ACT fidelity standards. **NOTE:** *If the standards are not being met, consideration should be given to dropping them from the program and no longer allowing them to use the MHICM stop codes.*

d. **Facility Director.** The facility Director is responsible for:

(1) Utilizing national DSS identifiers to designate MHICM activity.

(2) Providing complete nationally-adopted monitoring information for MHICM in a timely manner.

(3) Maintaining team fidelity to program operating principles (see subpar. 2e(2)) and adhering to evidence-based clinical procedures.

(a) Adequate resources are needed to provide a critical mass of staff to comprehensively address the needs of these exceptionally vulnerable patients, even in the face of staff turnover and other absences.

January 30, 2006

(b) At least four clinical FTE employees are needed for each MHICM team. Additional team members may be required in circumstances where the team is isolated from a VA medical center that can provide 24-hour coverage and emergency services. At sites where there are insufficient patients to justify a full team, consideration is to be given to partnering with the community, e.g., existing ACT teams. **NOTE:** *A model for rural MHICM teams where there is not a sufficient patient base for a full MHICM mode, is being developed.*

(4) Providing transportation (i.e., General Services Administration (GSA)-leased vehicles) and electronic communication technology resources (i.e., cell phones, laptops, etc.) to facilitate safe and efficient delivery of community-based services.

5. REFERENCES: See website at: <http://vaww.mentalhealth.med.va.gov/MHICMRef.shtm> for current clinical references.

6. FOLLOW-UP RESPONSIBILITY: The Deputy Chief Patient Care Services Officer for Mental Health (116) is responsible for the contents of this Directive. Questions may be directed to 203-937-3850.

7. RESCISIONS. VHA Directive 2000-034 is rescinded. This VHA Directive expires January 31, 2011.

Jonathan B. Perlin, MD, PhD, MSHA, FACP
Under Secretary for Health

Attachment

DISTRIBUTION: CO: E-mailed 2/01/06
FLD: VISN, MA, DO, OC, OCRO, and 200 - E-mailed 2/01/06

ATTACHMENT A

DECISION SUPPORT SYSTEM (DSS) IDENTIFIER (STOPCODES) FOR MENTAL HEALTH INTENSIVE CASE MANAGEMENT

Decision Support System (DSS) Identifier Number	DSS Identification Name	DESCRIPTION
546	TELEPHONE MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM)	Records patient consultation or psychiatric care, management, advice, and/or referral provided by telephone contact between patient or patient's next-of-kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical, professional staff assigned to the special MHICM teams (see 552). Includes administrative and clinical services. NOTE: <i>The patient's health information and treatment plans may only be discussed with individuals, such as next-of-kin, who are involved in the patient's care. Patient health information and treatment plans containing records which reveal the identity, prognosis, diagnosis, or treatment of Department of Veterans Affairs (VA) patients which relate to drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia, have additionally protections under Title 38 United States Code 7332 and may <u>not</u> be released or discussed even with individuals who are involved in the patient's care unless there is written authorization from the patient.</i>
552	MHICM	<u>Only VA medical centers approved to participate in MHICM programs monitored by Northeast Program Evaluation Center (NEPEC) may use this code.</u> This records visits with patients and/or their families or caregivers by MHICM staff at all locations including VA outpatient or MHICM satellite clinics, MHICM storefronts, MHICM offices, or home visits. Includes clinical and administrative services provided to MHICM patients by MHICM staff. Additional stop codes may not be taken for the same workload.
567	MHICM GROUP	<u>Only VA medical centers approved to participate in MHICM programs monitored by NEPEC may use this code.</u> This records group visits with patients and/or their families or caregivers by MHICM staff at all locations including VA outpatient or MHICM satellite clinics, MHICM storefronts, MHICM offices, or home visits. Includes clinical and administrative services provided MHICM patients by MHICM staff. Additional stop codes may not be taken for the same workload.
564	MENTAL HEALTH TEAM CASE MANAGEMENT	Records visits with patients and/or their families or caregivers by members of a mental health case management team performing mental health community case management at all locations. Includes administrative and clinical services provided to patients by team members. (NOT to be used for visits by MHICM teams [see DSS Identifier #552], or for case management by individuals who use other stop codes.)

Appendix B

MHICM Planning Material and Checklists

July 20, 2006

Director, NEPEC / VA MHICM/IPCC Project Director

MHICM Planning Guidelines

Facility or VISN Representative

1. Thank you for your interest in VA Mental Health Intensive Case Management (MHICM) programs (formerly known as Intensive Psychiatric Community Care or IPCC). In response to many inquiries about MHICM teams, we have assembled this package of materials and guidelines to help VA facility and network level planners evaluate the benefits of implementing an MHICM team. It includes:

A. Descriptive materials: 1) summary of the program's history and scientific foundation; 2) summary of the program's mission, objectives, and monitoring domains; 3) brief bibliography; 4) list of current MHICM teams.

B. Standards and Implementation Checklist: 1) outline of minimum standards and expectations for starting an MHICM team; 2) MHICM implementation checklist.

C. Report and literature: 1) FY 2005 NEPEC MHICM report; 2) 1998 IPCC outcomes paper.

2. Would you like to learn more about Mental Health Intensive Case Management (MHICM)?

To learn more about the history, principles, and outcomes of MHICM, review the descriptive materials and literature and VHA Directive 2000-034, "Mental Health Intensive Case Management", available at <http://vaww.va.gov/publ/direc/health/direct/12000034.htm> and Appendix A of the MHICM Annual Report.

3. Are you interested in starting an MHICM team at your facility or in your VISN?

To learn more about key elements of an MHICM team, review the enclosed minimum standards and the MHICM implementation checklist.

4. Have you considered reconfiguring an existing staff unit into an MHICM team? How closely do your community services resemble MHICM?

To compare a planned or existing program with MHICM services, review the enclosed minimum standards and complete the enclosed MHICM implementation checklist. Scoring your planned or existing community services team with the checklist will help us know how best to work with you.

**5. Could an MHICM team improve mental health services at your facility?
Could NEPEC training and monitoring enhance the effectiveness or efficiency of an
existing team?**

NEPEC publishes an annual report on MHICM teams with extensive information on program operation, as well as scientific papers in peer-reviewed journals. To learn more about NEPEC monitoring of MHICM teams, look at Chapter 2 in the FY 2005 report for tables on MHICM client characteristics, program structure, service delivery, clinical outcomes, and costs. Appendix A includes VHA Directive 2000-034, which defines MHICM services and monitoring. Appendix D provides a legend for each table. To learn more about MHICM outcomes, review the clinical and cost data from the Archives of General Psychiatry paper on the original IPCC experimental evaluation.

**6. Would you like NEPEC's assistance with starting or reconfiguring a team, training staff, or
monitoring outcomes at your facility?**

To request consultation and training to establish an MHICM team, to reconfigure an existing program to MHICM, or to include an existing community treatment team in NEPEC national monitoring, please send a completed copy of the enclosed MHICM Implementation checklist to:

Robert Rosenheck MD
Northeast Program Evaluation Center (NEPEC)/182
VA Connecticut Healthcare System
950 Campbell Avenue, West Haven, CT 06516
203-937-3850.

7. Thanks again for your interest in MHICM services for veterans with serious mental illness.
We hope the enclosed materials are helpful to you.

Robert Rosenheck, M.D.
Director, NEPEC

Michael Neale, Ph.D.
VA MHICM Project Director

What is MHICM?

VHA Mental Health Intensive Case Management (MHICM) teams provide community-based psychiatric and rehabilitation services to veterans with serious mental illness who are among the most frequent and long-term users of VA inpatient mental health resources. MHICM services are characterized by high staff -client ratios, shared caseloads, assertive outreach, frequent contact in community settings, a practical problem-solving approach, and high continuity of care. Interdisciplinary teams assume primary care responsibility and provide individualized care to help veterans: 1) reduce inpatient mental health service use and cost; 2) improve community adjustment and quality of life; and 3) enhance satisfaction with services. All MHICM veterans and staff participate in standardized national monitoring of program resources, client characteristics, service delivery, and outcomes in collaboration with the Northeast Program Evaluation Center (NEPEC). Evaluation and monitoring data have demonstrated the clinical and cost effectiveness of MHICM.

MHICM services are based on principles and standards of assertive community treatment (ACT), which has been identified as an evidence-based practice for people with serious mental illnesses. VHA Directive 2000-034 defines MHICM services and monitoring within VA. Cost effectiveness studies have shown that MHICM can be effective and efficient in the VA system. MHICM staffing standards (at least 3-4 FTEE) represent a minimum relative to published ACT standards (i.e., 8-15 FTEE). A MHICM team should have sufficient staff to provide the comprehensive, intensive community-based services the standards suggest. Because MHICM teams are less richly staffed than standard ACT teams, there are occasions when clients must be referred for day treatment, medical, substance abuse, or vocational services. On the other hand, location of MHICM teams within integrated VA mental health service systems allows most veterans to receive a range of services with continuous team support and minimal fragmentation.

The ninety-seven teams currently providing MHICM services to 5,600 veterans in 42 states nationwide and Puerto Rico are listed on the next page.

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VHA Mental Health Intensive Case Management (MHICM) Teams (June, 2006)

AL:	Birmingham		St. Louis
	Tuscaloosa	MT:	Fort Harrison
	Tuskegee	NE:	Omaha
AR:	Little Rock	NJ:	New Jersey (East Orange/Lyons)
AZ:	Phoenix	NM:	Albuquerque
	Tucson	NY:	Albany
CA:	Greater Los Angeles		Brooklyn
	Loma Linda		Buffalo
	Long Beach		Canandaigua
	Palo Alto		Hudson Valley (Montrose/Castle Pt.)
	San Diego		Northport
	San Francisco		Syracuse
CO:	Denver	NC:	Durham
	Grand Junction		Fayetteville
	Southern Colorado		Salisbury
CT:	West Haven	OH:	Akron
DC:	Washington		Chillicothe
FL:	Bay Pines		Cincinnati
	Gainesville		Cleveland
	Miami		Columbus
	Tampa		Dayton
	West Palm Beach		Mansfield
GA:	Atlanta		Youngstown
	Augusta	OK:	Oklahoma City
ID:	Boise	OR:	Portland
IL:	Chicago (West Side)	PA:	Coatesville
	Danville		Lebanon
	Hines		Philadelphia
	North Chicago		Pittsburgh
IN:	Indianapolis	PR:	San Juan
	Northern Indiana (Marion/Ft. Wayne)	SC:	Charleston
IA:	Central Iowa (Knoxville/Des Moines)		Columbia
	Iowa City	TN:	Memphis
KS:	Eastern Kansas (Topeka)		Nashville
KY:	Louisville	TX:	Dallas
LA:	New Orleans		Houston
ME:	Togus		San Antonio
MD:	Baltimore		Waco
	Perry Point	UT:	Salt Lake City
MA:	Bedford	VA:	Hampton
	Brockton		Salem
MI:	Ann Arbor	WA:	American Lake
	Battle Creek		Seattle
	Detroit	WV:	Martinsburg
MN:	Minneapolis	WI:	Madison
	St. Cloud		Milwaukee
MS:	Gulf Coast (Biloxi/Gulfport)		Tomah
	Jackson	WY:	Sheridan
MO:	Kansas City		

What is the history and success of MHICM?

Mental Health Intensive Case Management (MHICM) programs represent the adaptation, within VA, of **assertive community treatment (ACT)**, a model developed in the 1970's by Arnold Marx, Leonard Stein, and Mary Ann Test in Madison, Wisconsin (1-6). ACT is one of the most heavily researched psychiatric services for people with serious mental illness, recently recommended as a state of the art intervention by the Schizophrenia Patient Outcomes Research Team (PORT) study (7-8). The intent of ACT developers was to make the comprehensive services and support of an inpatient unit available to outpatients in the community, integrated within a single team. ACT helps people to reduce psychiatric inpatient hospital use and improve community adjustment, quality of life, and satisfaction with services (9-12). Fidelity data further demonstrate that the success of a given ACT team is influenced by team adherence to the model, staff cohesiveness, and host agency support for outpatient treatment (13-16). In 1998, the National Alliance for the Mentally Ill (NAMI) adopted the Madison ACT model as a central element of its national anti-stigma campaign and many states and communities established ACT teams within their mental health systems.

Initially funded as a regional mental health demonstration program in 1987, nine original MHICM teams were compared via experimental design with standard VA aftercare services. Two-year findings revealed that MHICM veterans had significantly fewer hospital days and lower costs overall than veterans receiving standard VA treatment. Clinically, MHICM veterans scored significantly lower in psychiatric symptoms, and higher in functioning and satisfaction with services (17-18). Five-year outcomes showed sustained reductions in hospital use and improvements in psychiatric symptoms, functioning, and personal well-being for MHICM clients (18). Compared to a randomly assigned control group, 454 MHICM veterans averaged 158 fewer hospital days over five years. After accounting for program costs, the nine MHICM programs were responsible for VA cost reductions estimated at \$12.8 million, or \$2.6 million per year. The program was most successful at facilities that adhered to the model and showed performance improvements in other areas as well (16).

With the demonstration's success, 30 new MHICM teams were funded in 1994-95 as part of a national VA initiative that used successful teams as mentors for developing programs. The issue of VHA Directive 2000-034 prompted further program expansion with facility and network resources. System-wide monitoring data (FY 1997-03) indicate that: 1) MHICM programs serve veterans with severe, long-standing disabilities (90% psychotic diagnosis; 47% hospitalized for more than two years; mean of 88 hospital days in year preceding entry; 49% funds managed by representative payee); 2) MHICM staff provide frequent, continuous services in the community; 3) MHICM veterans show substantial reductions in hospital use (mean 54 days per veteran during the first twelve months of treatment) with commensurate reductions in inpatient costs (\$48,427 per veteran for 3,190 veterans treated for twelve months); and 4) MHICM veterans show significant improvements in symptoms, functioning, quality of life, and satisfaction after six months in the program (19-21).

MHICM offers a tested and effective model for community-based treatment and rehabilitation of veterans with serious mental illness who are high users of VA psychiatric inpatient resources. It is consistent with principles underlying VA's recent reorganization that emphasize novel outpatient delivery systems, enhanced accessibility, customer satisfaction, and cost savings. On the basis of MHICM's demonstrated effectiveness, the Mental Health Strategic Healthcare Group (MHSHG) and the VA Under Secretary's Special Committee for Severely Chronically Mentally Ill Veterans (SMI Committee) have encouraged NEPEC to assist VA facilities and networks with MHICM team development by providing training, technical assistance, and monitoring.

What are the minimum standards for an effective MHICM team?

Successful implementation of MHICM requires the following explicit administrative commitments, warranted by past experience and the relative resource intensity of MHICM services:

- Target veterans with **serious mental illnesses** and **impaired community functioning** (typically psychotic disorders, with or without accompanying substance abuse) who are **high utilizers of VA inpatient, residential, or crisis mental health services** (for whom traditional services have not resulted in stable community adjustment);
- Provide a dedicated staff of **at least four clinicians** including at least one nurse as well as psychiatric and office support. Larger teams staff have generally proven to be more effective and enduring.
- Promote **team cooperation and morale** to enhance efficiency and continuity (crucial to team success);
- Identify a **team leader** whose duties include liaison with VA and community representatives, supervision of MHICM staff, and delivery of clinical services in the community;
- Support **frequent client contact** and **delivery of clinical services in the community**, including in vivo assessment, medication delivery, skills training, and rehabilitation services.
- Assure **off-hours team access** for guidance of inpatient and emergency clinical staff;
- Provide **ancillary resources** for safe and efficient community services, including:
 - fixed, economical **team space**, at or near the medical center/clinic;
 - dedicated **vehicles** for daily community visits by each clinician;
 - dedicated **communication technology** (beepers, cell phones) to assure staff and client safety;
 - electronic **office technology** (computers, copier, answering machine, fax machine) for organizing, charting, and monitoring clinical work;
- Establish **integrated links** between the MHICM team and other mental health / rehabilitation services (inpatient, outpatient, and community) to enhance service coordination;
- Maintain a **clear line of authority**, with the team leader represented in the mental health service or product line; and
- Assure **quality and accountability through monitoring** of program effectiveness and cost.

Program Objectives and Principles

MHICM services are delivered by integrated, multidisciplinary teams and are based on the Substance Abuse Mental Health Services Administration (SAMHSA) ACT standards. MHICM teams seek to deliver high quality services that:

- provide intensive, flexible community support;
- improve health status (reduce psychiatric symptoms & substance abuse);
- reduce psychiatric inpatient hospital use and dependency;
- improve community adjustment, functioning, and quality of life;
- enhance satisfaction with services; and
- reduce treatment costs.

To accomplish these objectives, MHICM teams adhere to four core treatment elements:

- Intensity of Contact. High intensity of care primarily through home and community visits, with low caseloads (seven to fifteen veterans per clinician), allowing rapid attention to crisis and development of community living skills to prevent crisis in this exceptionally vulnerable population.
- Flexibility and Community Orientation. Flexibility and community orientation with most services provided in community settings and involving integration with natural support systems whenever possible (e.g., family members, landlords, employer).
- Rehabilitation Focus. Focus on rehabilitation through practical problem solving, crisis resolution, adaptive skill building, and transition to self-care and independent living where possible.
- Continuity and Responsibility. Identification of the team as a “fixed point of clinical responsibility” providing continuity of care for each veteran, wherever the veteran happens to be, for at least one year, with subsequent care subject to review of continuing need for intensive services.

VHA Directive 2000-034 establishes procedural guidelines for MHICM teams, operationalized in eight **minimum program standards** that serve to complement the critical performance monitors.

Minimum standard	Threshold value
➤ Percent of veterans with psychotic diagnosis at entry	(50% or more)
➤ Percent of veterans with 30 or more psychiatric inpatient days in year before entry	(50% or more)
➤ Mean adjusted face-to-face contacts per week/veteran	(1.0 or more)
➤ Ratio of veterans to clinical FTEE (mean caseload)	(7:1 to 15:1)
➤ Percent of veterans for whom at least 60% of contacts occur in community setting	(50% or more)
➤ Percent of veterans receiving psychiatric rehabilitation or skills training services	(25% or more)
➤ Percent of veterans discharged from MHICM program	(< 20%)
➤ Number of clinical service providers on the team	(4.0+ FTEE).

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References

1. Marx AJ, Test MA, Stein LI: Extrohospital management of severe mental illness. *Archives of General Psychiatry* 29:505-511, 1973.
2. Stein LI, Diamond RJ: A program for difficult-to-treat patients. In LI Stein, MA Test (eds.) *The Training in Community Living Model: A Decade of Experience*. New Directions for Mental Health Services, no.26. San Francisco, Jossey-Bass, 1985.
3. Stein LI, Test MA: Alternative to mental hospital treatment, I: Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry* 37, 392-397, 1980.
4. Test MA. (1992). Training in community living. In RP Liberman (ed.), *Handbook of psychiatric rehabilitation*. New York: MacMillan.
5. Allness DJ & Knoedler WH. (2003). *A Manual for ACT Start-Up*. Waldorf, MD: NAMI www.nami.org.
6. Stein LI, Santos AB: Assertive community treatment of persons with severe mental illness. New York: Norton, 1998.
7. Lehman AF, Steinwachs DM, Co-investigators of the PORT project: Translating research into practice: The schizophrenia patient outcomes research team (PORT) treatment recommendations. *Schizophrenia Bulletin*, 24(1):1-10 1998.
8. Lehman AF, Kreyenbuhl J, Buchanan R, Dickerson F, Dixon L, Goldberg R, Green-Paden L, Tenhula W, Boerescu D, Tek C, Sandson N, Steinwachs D: The Schizophrenia Patient Outcomes Research Team (PORT): Updated Treatment Recommendations 2003, *Schizophrenia Bulletin*, 30 (2):193-217, 2004.
9. Olfson M: Assertive community treatment: An evaluation of the experimental evidence. *Hospital and Community Psychiatry* 41:634-641, 1990.
10. Burns BJ, Santos AB: Assertive community treatment: An update of randomized trials. *Psychiatric Services* 46:669-675, 1995.
11. Scott JE, Dixon LB: Assertive community treatment and case management for schizophrenia. *Schizophrenia Bulletin* 21(4):657-668, 1995.
12. Mueser KT, Bond GR, Drake RE et al: Models of community care for severe mental illness: A review of research on case management. *Schizophrenia Bulletin* 24(1):37-74, 1998.
13. Brekke JS, Test MA: A model for measuring the implementation of community support programs: Results from three sites. *Community Mental Health Journal* 28, 227-247, 1992.
14. McGrew JH, Bond GR: The association between program characteristics and service delivery in assertive community treatment. *Administration and Policy in Mental Health* 25:175-189, 1997.
15. Teague GB, Bond GR, Drake RE: Program fidelity in assertive community treatment: Development and use of a measure. *American Journal of Orthopsychiatry* 68(2): 216-232, 1998.
16. Rosenheck RA, Neale MS: Intersite variation in impact of intensive psychiatric community care on hospital use. *American Journal of Orthopsychiatry* 68:191-200, 1998b.
17. Rosenheck R, Neale M, Leaf P, Milstein R, Frisman L. (1995). Multisite experimental cost study of intensive psychiatric community care. *Schizophrenia Bulletin*, 21: 129-140.
18. Rosenheck RA, Neale MS: Cost-effectiveness of intensive psychiatric community care for high users of inpatient services. *Archives of General Psychiatry* 68:191-200, 1998a.
19. Rosenheck RA, Neale MS, Baldino R, Cavallaro L. (1997). Intensive psychiatric community care (IPCC): Dissemination of a new approach to care for veterans with serious mental illness in the department of veterans affairs. West Haven, CT (203-937-3851): VA Northeast Program Evaluation Center Report.
20. Neale MS, Rosenheck RA, Martin A, Morrissey J, Castrodonatti, J. 2003. Mental health intensive case management (MHICM) in the department of veterans affairs: The sixth national performance monitoring report - FY 2002. West Haven, CT: Northeast Program Evaluation Center report (www.nepec.org).
21. Neale MS, Rosenheck RA, Castrodonatti J, Martin A, Morrissey J, Anderson J. 2004. Mental health intensive case management (MHICM) in the department of veterans affairs: The seventh national performance monitoring report - FY 2003. West Haven, CT: Northeast Program Evaluation Center report (www.nepec.org).

Bibliography: Assertive Community Treatment and Mental Health Intensive Case Management

1. Allness DJ & Knoedler WH. (2003). A Manual for ACT Start-Up. Waldorf, MD: NAMI (www.nami.org).
2. Brekke JS, Test MA. 1992. A model for measuring the implementation of community support programs: Results from three sites. *Community Mental Health Journal* 28, 227-247, 1992.
3. Burns BJ, Santos AB. 1995. Assertive community treatment: An update of randomized trials. *Psychiatric Services*, 46: 669-675.
4. Drake RE, Burns BJ, eds. 1995. ACT special section. *Psychiatric Services*, 46: 667-721.
5. Drake RE, Burns BJ, eds. 1998. ACT special section. *American Journal of Orthopsychiatry*, 68: 172-264.
6. Lehman AF, Steinwachs DM, Co-investigators of the PORT project. 1998. Translating research into practice: The schizophrenia patient outcomes research team (PORT) treatment recommendations. *Schizophrenia Bulletin*, 24: 1-10.
7. Marx AJ, Test MA, Stein LI. 1973. Extrohospital management of severe mental illness. *Archives of General Psychiatry*, 29: 505-511.
8. McGrew J, Bond GR. 1995. Critical ingredients of assertive community treatment: Judgments of the experts. *The Journal of Mental Health Administration*, 22: 113-125.
9. McGrew J, Bond GR. 1997. The association between program characteristics and service delivery in assertive community treatment. *Administration and Policy in Mental Health*, 25:175-189.
10. Mueser KT, Bond GR, Drake RE, Resnick SG. 1998. Models of community care for severe mental illness: A review of research on case management. *Schizophrenia Bulletin*, 24:37-74.
11. Neale MS, Rosenheck RA. 1995. Therapeutic alliance and outcome in a VA intensive case management program. *Psychiatric Services*, 46: 719-721.
12. Neale, MS, Rosenheck, RA. 2000. Therapeutic limit setting in assertive community treatment. *Psychiatric Services*, 51, 499-505.
13. Neale MS, Rosenheck RA, Hogu T, Martin A. 2001. Mental health intensive case management (MHICM) in the department of veterans affairs: The fourth national performance monitoring report – FY 2000. West Haven, CT, Northeast Program Evaluation Center report (www.nepec.org).
14. Neale MS, Rosenheck RA, Hogu T, Martin A. 2002. Mental health intensive case management (MHICM) in the department of veterans affairs: The fifth national performance monitoring report – FY 2001. West Haven, CT: Northeast Program Evaluation Center report (www.nepec.org).
15. Neale MS, Rosenheck RA, Martin A, Morrissey J, Castrodonatti, J. 2003. Mental health intensive case management (MHICM) in the department of veterans affairs: The sixth national performance monitoring report - FY 2002. West Haven, CT: Northeast Program Evaluation Center report (www.nepec.org).
16. Neale MS, Rosenheck RA, Castrodonatti J, Martin A, Morrissey J, Anderson J. 2004. Mental health intensive case management (MHICM) in the department of veterans affairs: The seventh national performance monitoring report - FY 2003. West Haven, CT: Northeast Program Evaluation Center report (www.nepec.org).
17. Olfson M. 1990. Assertive community treatment: An evaluation of the experimental evidence. *Hospital and Community Psychiatry* 41: 634-641.
18. Phillips SD, Burns B, Edgar E, Mueser K, Linkins K, Rosenheck R, Drake R, McDonell Herr E. 2001. Moving assertive community treatment into standard practice. *Psychiatric Services*, 52: 771-9.
19. Rosenheck RA, Neale MS. 1998. Cost-effectiveness of intensive psychiatric community care for high users of inpatient services. *Archives of General Psychiatry*, 55: 459-466.
20. Rosenheck RA, Neale MS. 1998. Inter-site variation in impact of intensive psychiatric community care on hospital use. *American Journal of Orthopsychiatry*, 68: 191-200.

21. Rosenheck RA, Neale MS. 2001. Development, implementation, and monitoring of intensive psychiatric community care in the department of veterans affairs. In B Dickey and L Sederer (Eds.), *Achieving Quality in Psychiatric and Substance Abuse Practice: Concepts and Case Reports*. Washington DC: American Psychiatric Press.
22. Rosenheck RA, Neale MS. 2004. Therapeutic limit-setting and 6-month outcomes in assertive community treatment. *Psychiatric Services*, 55, 139-144.
23. Rosenheck RA, Neale MS, Baldino R, & Cavallaro L. 1997. Intensive psychiatric community care (IPCC): Dissemination of a new approach to care for veterans with serious mental illness in the department of veterans affairs. West Haven, CT (203.937-3851): Northeast Program Evaluation Center report (www.nepec.org).
24. Rosenheck RA, Neale MS, Leaf P, Milstein R, & Frisman L. 1995. Multisite experimental cost study of intensive psychiatric community care. *Schizophrenia Bulletin*, 21: 129-140.
25. Santos AB, ed. 1997. ACT special section. *Mental Health Administration & Policy*, 25: 101-220.
26. Scott JE, Dixon LB. 1995. Assertive community treatment and case management for schizophrenia, *Schizophrenia Bulletin* 21(4): 657-668.
27. Stein LI, Diamond RJ. 1985. A program for difficult-to-treat patients. In LI Stein, MA Test (eds.) *The Training in Community Living Model: A Decade of Experience*. New Directions for Mental Health Services, no.26. San Francisco, Jossey-Bass.
28. Stein LI, Test MA. 1980. Alternative to mental hospital treatment, I: Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry*, 37: 392-397.
29. Stein LI & Santos AB. 1998. *Assertive Community Treatment of Persons with Severe Mental Illness*. New York: WWNorton.
30. Teague GB, Bond GR, Drake RE. 1998. Program fidelity in assertive community treatment: Development and use of a measure. *American Journal of Orthopsychiatry*, 68(2): 216-232.
31. Test MA. 1992. Training in community living. In RP Liberman (ed.), *Handbook of psychiatric rehabilitation*. New York: MacMillan.

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**VA MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM) TEAM
IMPLEMENTATION CHECKLIST FOR FY 2004 ANNUAL REPORT**

September 15, 2004

This is a checklist of primary criteria and recommended operational standards for use in evaluating a current MHICM team. The checklist is based on current VA criteria for MHICM teams and published CARF standards for Assertive Community Treatment (ACT). All program elements should be in place within the first year of team development. **Please indicate whether each element is in place for your team at the end of FY 2004. If "No", briefly identify a reason or obstacle to be addressed. Record site identification data and general comments or questions below and return with your team's FY 2004 Annual Report by November 15, 2004. If you have questions about checklist items, please call Mike Neale Ph.D., VHA MHICM Project Director at 203.932.5711x3696. Thank you.**

Site Identification Data:

Submitting Facility/VISN: _____

Contact Person/Title: _____

Phone: _____ Fax: _____

Address: _____

Alternate Contact Person/Title: _____

Phone: _____ Fax: _____

Current MHICM FTEE? _____ Current MHICM team caseload? _____

Current MHICM vehicles? _____ Percent of staff time spent in community? _____

General Comments, Questions:

VA MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM) TEAM IMPLEMENTATION CHECKLIST

September 15, 2004

PRIMARY PROGRAM CRITERIA:

<u>Element</u>	<u>In Place/Planned?</u>	<u>Why Not?</u>
----------------	--------------------------	-----------------

I. MHICM Target Population

MHICM veterans will meet all five of the following admission criteria:

- | | |
|--|------------|
| 1. diagnosis of severe and persistent mental illness (e.g., schizophrenia, bipolar disorder, major affective disorder, severe PTSD) with or without substance abuse; | Yes__ No__ |
| 2. severe functional impairment (i.e., veteran is not currently capable of successful and stable maintenance in a community living situation or participation in necessary treatment without intensive support); | Yes__ No__ |
| 3. inadequately served by or unable to achieve a stable community adjustment with conventional clinic-based outpatient treatment or day treatment; and | Yes__ No__ |
| 4. high hospital use (i.e. 30 or more days or 3 or more episodes of psychiatric inpatient care in the year preceding MHICM admission). | Yes__ No__ |
| 5. clinically appropriate for MHICM rather than inpatient care. | Yes__ No__ |

II. MHICM Program Description

- | | |
|--|------------|
| 1. MHICM services will be delivered by an integrated, multi-disciplinary team with a minimum of 4.0 designated clinical FTE who provide services in the community. | Yes__ No__ |
| | Yes__ No__ |
| | Yes__ No__ |

<u>Element</u>	<u>In Place/Planned?</u>	<u>Why Not?</u>
----------------	--------------------------	-----------------

II. MHICM Program Description (continued):

Core Elements (continued)

2. MHICM services will be characterized

by five core treatment elements, including:

- | | |
|---|------------|
| A. high intensity of care (primarily through home & community visits) | Yes__ No__ |
| with low caseloads (7-15 veterans per 1.0 clinical FTE), | Yes__ No__ |
| rapid attention to crisis and | Yes__ No__ |
| development of community living skills to prevent crisis; | Yes__ No__ |
| B. flexibility & community orientation with most services provided in community settings and involving natural support systems (family, landlord, employer) whenever possible; | Yes__ No__ |
| C. focus on rehabilitation through practical problem solving, crisis resolution, adaptive skill building, and transition to self-care and independent living where possible; | Yes__ No__ |
| D. identification of the team as a “fixed point of clinical responsibility” providing continuity of care for each veteran wherever s/he happens to be, for a prolonged period (initially 1 year, then based on periodic review of continuing need for services); and | Yes__ No__ |
| E. appropriate transition to standard care or lower intensity MHICM treatment when a veteran is: clinically stable, not abusing addictive substances, not relying on inpatient/ER services, capable of maintaining self in a community living situation, and independently participating in necessary treatments. | Yes__ No__ |

III. Accountability

Each MHICM team/clinician will:

- | | |
|--|------------|
| 1. Utilize national DSS identifiers to designate MHICM workload; | Yes__ No__ |
| 2. Maintain fidelity to MHICM operating principles and evidence-based clinical procedures; and | Yes__ No__ |

<u>Element</u>	<u>In Place/Planned?</u>	<u>Why Not?</u>
----------------	--------------------------	-----------------

III. Accountability (continued)

- | | | |
|--|------------|--|
| 3. Provide complete and timely MHICM monitoring information, including: | Yes__ No__ | |
| A. Standard Intake Data Form (IDF) completed with all new admissions, | Yes__ No__ | |
| B. Follow-Up Data Form (FDF) completed with each program veteran at 6 months and annually after entry, | Yes__ No__ | |
| C. Clinical Progress Report (CPR) completed by each veteran's primary case manager at 6 months and annually after entry, | Yes__ No__ | |
| D. FTE/Caseload Report completed monthly by the team leader, | Yes__ No__ | |
| E. Log of veterans treated, with entry / discharge dates, and dates for completing monitoring data. | Yes__ No__ | |
| F. Brief annual progress report on program developments, staffing, workload, projected/actual expenditures, including standards and fidelity checklists, due on November 15th each year, | Yes__ No__ | |

RECOMMENDED OPERATIONAL STANDARDS

IV. Staffing

- | | |
|---|------------|
| 1. Full-time team leader with master's level degree in mental health field (social work, psychology, nursing, counseling/guidance, rehabilitation) and 2000 hours (2 years) of post-degree treatment of people with serious mental illness. | Yes__ No__ |
| 2. Minimum of eight hours (.20 FTE) psychiatrist time for every 50 vets. | Yes__ No__ |
| 3. Minimum of 1.0 FTE RN and clearly designated, accessible nursing backup. | Yes__ No__ |
| 4. Minimum of three-fourths of clinical staff with at least a bachelor's degree in a mental health field. | Yes__ No__ |
| 5. Physician/nurses collaborate with other clinical staff to manage a system for prescribing/administering medications. | Yes__ No__ |
| 6. One or more staff designated to organize daily planning of team activities. | Yes__ No__ |
| 7. One or more staff with team chart auditing (QA) responsibilities. | Yes__ No__ |

<u>Element</u>	<u>In Place/Planned?</u>	<u>Why Not?</u>
----------------	--------------------------	-----------------

V. Hours of Coverage and Access

1. Team identifies regular hours of service with at least 8 hrs on 5 days/week and evening/weekend hours as appropriate. Yes__ No__
2. Hospital/ER staff have 24-hour, 365-day on-call access to team for crisis, admission, discharge consultation. Yes__ No__

VI. Communication and Daily Planning

1. Daily, M-F team meetings to review client status and organize/assign daily work of team. Rotated leadership. Yes__ No__
2. Integration of individual schedules for client contact (see treatment planning), emerging client needs, and team clinical responsibilities into daily work assignment. Yes__ No__
3. Recording of all client services and encounters, for purposes of auditing, workload credit, and evaluation. Yes__ No__
4. All staff remain accessible during work hours via beeper, pager, cellular phone. Yes__ No__

VII. Record-keeping

1. Charts contain basic sections: identifying data problem list; treatment plans/reviews; progress notes; intake/history; medications/lab results/consults; hospital summaries; clinical assessments/screenings; signed correspondence/releases; & consents/administrative. Yes__ No__
2. Progress notes within local guidelines re: frequency/format, including: assessments of: clinical status, danger to self/others; medication compliance; significant events & status changes; general goals/treatment planning; client/family education; location & frequency of contact; clear goals. Yes__ No__
3. Initial assessment done within 4 wks of entry & in chart, covering: psychiatric/psychological (with DSM-IV diagnosis), family/other supports, instrumental ADL, vocational, housing, medical/dental, substance abuse. Yes__ No__

<u>Element</u>	<u>In Place/Planned?</u>	<u>Why Not?</u>
----------------	--------------------------	-----------------

VII. Record-keeping (continued)

- | | |
|--|------------|
| 4. Treatment plan signed by multidisciplinary team in chart within 4 wks of entry and reviewed every 6 mos or as needed. | Yes__ No__ |
|--|------------|

VIII. Treatment Planning

- | | |
|---|------------|
| 1. Weekly meetings for in-depth review of client treatment plans (1-2 clients per hour mtg), including current status & priorities, strengths & needs, short & long-term goals, staff activities & assignments. | Yes__ No__ |
| 2. Multi-disciplinary treatment review schedule determined weeks ahead. | Yes__ No__ |
| 3. Clear leadership of meetings. | Yes__ No__ |
| 4. Problems, goals, plans, & priorities all specific & interpretable, with clear staff roles and activities. | Yes__ No__ |
| 5. Treatment plan tasks and goals copied to client weekly/monthly schedule, for use in daily planning. | Yes__ No__ |
| 6. Treatment plan reviewed with and co-signed by client. | Yes__ No__ |

IX. Treatment and Rehabilitation Services

- | | |
|--|------------|
| 7. Primary clinician assigned for each client, although team provides multi-disciplinary treatment for each client. | Yes__ No__ |
| 8. Two or more staff with complementary skills / training identified on treatment plan to provide clinical services for each client. | Yes__ No__ |
| 9. Team provides a broad range of services for assigned clients as clinically indicated: advocacy; coordination; assessment & monitoring of symptoms/stressors/risks/ coping/med compliance/activities/skill levels; planning; help/skills training for daily tasks (ADLs, shopping); family support/education, and crisis intervention (see treatment plans). | Yes__ No__ |
| 10. Team initially sees each client for 2-3 substantial contacts per week on average with more frequent direct or phone contact as clinically indicated. | Yes__ No__ |

<u>Element</u>	<u>In Place/Planned?</u>	<u>Why Not?</u>
----------------	--------------------------	-----------------

IX. Treatment and Rehabilitation Services (continued)

- | | | |
|---|------------|--|
| 11. On a typical working day, at least 20% of clients are seen. | Yes__ No__ | |
| 12. Clinicians spend 50-75% of work time providing treatment / rehabilitation services in community settings. | Yes__ No__ | |
| 13. Team serves as fixed point of clinical responsibility with a long-term commitment to care of each client as clinically indicated. Initial expectation is for at least one year. | Yes__ No__ | |
| 14. Team assumes primary clinical responsibility for assigned clients. | Yes__ No__ | |

X. Assessments

- | | | |
|---|------------|--|
| 1. Assessments in charts (see IV-19). | Yes__ No__ | |
| 2. Assessments completed by members of multi-disciplinary team, considering specific training or expertise: | | |
| Psychiatric..psychiatrist | | |
| Vocational..team professional staff, | | |
| voc rehab specialist | | |
| ADL..team professional staff | | |
| Leisure time..team professional staff | | |
| Family..team professional staff | | |
| Medical..RN/MD | Yes__ No__ | |

XI. Admission / Discharge Criteria

- | | | |
|---|------------|--|
| 1. Admission criteria are clearly stated in policy statement and communicated to referring services, including client willingness to participate (i.e., signed releases, consents). | Yes__ No__ | |
| 2. Criteria for discharge or transition to lower intensity services are clearly stated in policy statement, including: clinically stable, not abusing addictive substances, not relying on extensive inpatient or emergency services, capable of maintaining self in a community living situation, and independently participating in necessary treatments. | Yes__ No__ | |

Assertive Community Treatment Fidelity Scale

Please complete all items without an "X" for this edited scale.
The scale and contact sheet are on six pages.

Form A (1)

VA Facility Name: _____

1. Five-Digit Facility code _____ (6)

Local name of the Team/Program:

_____ (8)

2. Target population (*list one letter from the categories below*) (9)

A. Seriously mentally ill veterans (non substance abuse)

B. Seriously mentally ill veterans (primarily substance abuse)

X3. Item deleted (leave response areas blank). x_____x (10)

x_____x (12)

X4. Item deleted (leave response areas blank).

x_____x (13)

X5. Items deleted (leave response areas blank).

x_____x (17)

x_____x (21)

x_____x (25)

x_____x (29)

x_____x (33)

x_____x (37)

x_____x (41)

6. Regarding your clients:

x_____x (43)

A. How many veterans are currently in treatment in this program? (46)

B. How many veterans is the program designed to treat when it is operating at full capacity? (49)

X7. Item deleted (leave blank). x\$_____x (56)

X8. Items deleted (leave response areas blank).

x_____x (59)

x_____x (62)

x_____x (65)

9. In what year was the program first implemented? 19 or 20 ____ ____ (67)

Answer the following with the categories directly beneath the question.

10. What is the caseload of your program? (68)

- A. 10 or fewer clients per clinician
- B. 11—20 clients per clinician
- C. 21—34 clients per clinician
- D. 35—49 clients per clinician
- E. 50 or more clients per clinician

11. What percent of clients have contact with more than one staff member in a given week? (69)

- A. 90% or more
- B. 64—89%
- C. 37—63%
- D. 10—36%
- E. 10% or fewer

12. How frequently do the team members meet to plan or review services for each client? (70)

- A. Program meets 4—5 days/week and usually reviews each client, even if only briefly
- B. Program meets 2—3 days/week and usually reviews each client, even if only briefly
- C. Program meets 1 day/week and usually reviews each client, even if only briefly
- D. Program meets 1 day every other week and usually reviews each client, even if only briefly
- E. Program meets 1 day per month or less and usually reviews each client, even if only briefly

13. How much of the time does the program's supervisor /director/coordinator provide services to clients? (71)

- A. Normally, at least 50% of the time
- B. Normally, between 25% and 50% of the time
- C. Routinely as backup, or normally less than 25% of the time
- D. On rare occasions as backup
- E. Supervisor provides no direct services to clients

14. How much staff turnover has the program experienced in the *past two* years? (72)

- A. Less than 20%
- B. 20—39%
- C. 40—59%
- D. 60—80%
- E. More than 80%

15. At what percent of full staffing has the program been operating for the *past twelve* months? (73)

- A. 95% or more
- B. 80—94%
- C. 65—79%
- D. 50—64%
- E. less than 50%

16. Does the program have a defined target population and explicit admission criteria? (74)
- A. The program actively recruits a defined population and all cases comply with explicit admission criteria.
 - B. The program typically actively seeks and screens referrals carefully, but occasionally bows to organizational pressure.
 - C. The program makes an effort to seek and select a defined set of clients, but accepts most referrals.
 - D. The program has a generally defined mission, but the admission process is dominated by organizational convenience.
 - E. The program has no set criteria and takes all types of cases, as determined outside the program.
17. Over the past six months, the highest monthly *intake* rate (that is, how many new clients have been admitted to the program) per month has been:..... (75)
- A. No greater than 6 per month
 - B. 7—9 per month
 - C. 10—12 per month
 - D. 13—15 per month
 - E. 16 or more per month
18. Which of the following five types of treatment services does your program offer? (Check all that apply)
- A. Counseling/psychotherapy (76)
 - B. Housing support (77)
 - C. Substance abuse treatment (78)
 - D. Employment/ vocational rehabilitation (79)
 - E. Rehabilitative services (80)
19. What role does the program have in providing crisis services to its clients?..... (81)
- A. The program provides 24 hour coverage
 - B. The program provides emergency service backup; e.g., program is called, makes a decision about need for direct program involvement.
 - C. The program is available by telephone, predominately in a consulting role.
 - D. Emergency service has program-generated protocol for program clients.
 - E. The program has no responsibility for handling crises after hours.
20. In what percent of hospital admissions of program clients are staff involved in the decision to admit? (82)
- A. 95% or more
 - B. 65—94%
 - C. 35—64%
 - D. 5—34%
 - E. 4% or less

21. In what percent of hospital discharge plans for program clients are program staff involved in developing the plan (planned jointly or in cooperation with the hospital staff)? (83)
- A. 95% or more
 - B. 65—94%
 - C. 35—64%
 - D. 5—34%
 - E. 4% or less
22. What percent of program clients are discharged from the program within one year of program entry? (84)
- A. 6% or fewer
 - B. 6—17%
 - C. 18—37%
 - D. 38—90%
 - E. 91% or more
23. What percent of time with clients is spent in the community (rather than in the office)? (85)
- A. 80% or more
 - B. 60—79%
 - C. 40—59%
 - D. 20—39%
 - E. 19% or less
24. What percent of the team caseload is retained over a twelve month period? (86)
- A. 95% or more
 - B. 80—94%
 - C. 65—79%
 - D. 60—64%
 - E. 59% or less
25. Does the program use street outreach and/or legal mechanisms (such as representative payees, probation/parole, outpatient commitment) to engage clients, as clinically indicated? (87)
- A. The program has a strategy that includes street outreach and legal mechanisms whenever appropriate
 - B. The program has a strategy and uses most of the mechanisms that are available
 - C. Program attempts outreach but uses legal mechanisms only as convenient
 - D. Program makes initial attempts to engage but generally focuses efforts on most motivated clients.
 - E. The program almost never uses street outreach.
26. On average, how much service time does each client receive per week? (88)
- A. 2 hours or more
 - B. 85—119 minutes
 - C. 50—84 minutes
 - D. 15—49 minutes
 - E. 14 minutes or less
27. On average, how many service contacts are made with each client per week? (89)
- A. 4 or more per week
 - B. 3 per week
 - C. 2 per week
 - D. 1 per week
 - E. less than 1 per week

28. For clients who have a support network, such as family, landlords, or employers, on average how many staff contacts are made with members of support network per month? _____ (90)
- A. 4 or more per month
 - B. 3 per month
 - C. 2 per month
 - D. 1 per month
 - E. less than 1 per month
29. For clients with a substance use disorder, how many minutes per week of substance abuse treatment do they receive from program staff? _____ (91)
- A. 24 minutes per week or more
 - B. 17—23 minutes per week
 - C. 10—16 minutes per week
 - D. 3—9 minutes per week
 - E. 2 minutes per week or fewer
30. What percent of clients with a substance use disorder attend group treatment that is provided by program staff? _____ (92)
- A. 50% or more
 - B. 35—49%
 - C. 20—34%
 - D. 5—19%
 - E. 4% or fewer
31. For clients with both serious psychiatric illness and a substance use disorder, to what extent does the program employ an integrated “dual disorders” model that is stage-wise, non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence) ? . _____ (93)
- A. The program is fully based on such DD treatment principles, with treatment provided by program staff
 - B. The program primarily uses such a DD model, with some substance abuse treatment provided outside the program
 - C. The program uses a mixed model, including both DD and non-DD principles
 - D. The program uses primarily a traditional model
 - E. The program is fully based on a traditional model
32. What DSS Identifiers (formerly called “stop codes”) are used to document the work of this program?
- A. First DSS identifier (typically 552) _____ (96)
 - B. Second DSS identifier (typically 546) _____ (99)
 - C. Third DSS identifier (if applicable) _____ (102)

Contact person or Person completing this form:

Name _____

Telephone number (with area code and extension): () _____ x _____

Fax number: () _____

Email (Internet) Address: _____

Address information (street, building, mail stop, city, state, zip):

If you have questions about the survey or items, please contact:

Mike Neale PhD: (203) 932-5711 x 3696

General comments accompanying the survey are welcome.

Please attach the survey to the Annual Report.

Appendix C

Outlier Review Request and Form

April 3, 2005

Director, NEPEC / VA MHICM Project Director

FY 2005 Performance and Minimum Standards Outlier Review

MHICM Program Directors, Clinical and Clerical Staff

1. **Tables:** Draft Tables 2-1 to 2-32 for the FY 2005 MHICM National Performance Monitoring Report, have been placed on the NEPEC intranet page, <http://vawww.nepec.mentalhealth.med.va.gov/>, for field review, along with Appendix D which provides a legend for each table and variable. We are also forwarding a copy of the relevant files by Outlook e-mail. As with previous reports, MHICM performance and critical monitors are listed in Table 2-1 and data are presented in Adobe Reader (.pdf Version 6.0) formatted Tables 2-2 to 2-32. You may need to download a more recent version of Adobe Acrobat Reader to view or print them. A download link for the software is available on the NEPEC home page (see above). Please consult your local IRM office if necessary.
2. **Outliers:** Please review your team's data on all tables and complete and return an outlier review for any **shaded** value on the monitoring and minimum standards tables. Outlier values are those for which a team's value exceeds the threshold for a critical monitor. Outliers in the *desired* direction, underlined in **bold**, require no response. Outlier values in the *undesired* direction are **shaded** in Tables 2-2 to 2-25 and **outlined** in summary tables (2-27 to 2-32) for each of the four monitoring domains (structure, client, service delivery, outcome) and the eight Minimum Program Standards.
3. **New Outlier Review Process:** To streamline the outlier review process this year, Joe will send an e-mail message to each team with an outlier summary sheet specific to the team's performance. Teams with outliers in the **undesired** direction need only: 1) Locate the outlier; 2) Check the data; 3) Select a reason for outlier status; 4) Give a brief explanation or plans to correct the team value; and 5) Email a completed copy back to Joe by Tuesday, April 25th.
4. **Next Steps:** Teams with negative outlier values in FY 2005 may want to consider adjusting team resources or operation to bring performance within the desired range for FY 2006. Teams with no outliers will be suitably rewarded.
5. **Note: Only negative (shaded) outliers for critical monitors indicated in the Outlier Summary Tables {Tables 2-27 through 2-32} require formal outlier response using the outlier review form you will receive by email.** Currently, this does not include outliers indicated for ACT Fidelity, Housing Independence, 6/12/18/24-month hospital use, IADLs, or Service Satisfaction. We have provided outlier feedback on these additional variables to assist your team in planning and to indicate areas where changes may be necessary to improve performance
6. If you have questions or comments about a particular measure or criterion value, or the review process, please contact Joe Castrodonatti by phone: 203.932.5711x3618 or Outlook.
7. Thank you all for your daily efforts on behalf of veterans with serious mental illness.

Robert Rosenheck, M.D.

Michael Neale, Ph.D.

List of Critical Monitors and Minimum Standards for Outlier Review, FY 2005 Draft Tables

Critical Monitor	Table	Column	MS#
<i>Team Structure (Table 2-28)</i>			
1. FTE Unfilled: more than 6 months (Y)	2-5	7	
2. Unassigned Medical Support: MD and/or RN (Y)	2-6	3	
3. Unassigned Medical Support: MD and/or RN (Y)	2-6	4	
4. Caseload Size: Mean Ratio Clients per Clinical FTEE (LT 7, GT15)	2-6	7	4
5. Team Size: # Full-time Clinical Staff (4.0+FTEE)	2-5	6	8
<i>Client Characteristics (Table 2-29)</i>			
6. % Clients with GTE 30 Days Hospital Yr Pre (LT 50%)	2-10	5	2
7. % Clients with Psychotic Diagnosis at Entry (GT 50%)	2-10	6	1
8. Mean GAF at Entry Exceeds 50 (GT 50)	2-11	6	
<i>Clinical Process (Table 2-30)</i>			
9. Tenure: % Clients Discharged (>20%)	2-12	5	7
10. Intensity: % Clients Seen GTE 1 Hour per wk (LT 1 Hr/Wk)	2-13	6	
11. Location: % Clients seen 60% or more in community (LT 50%)	2-13	7	5
12. Frequency: # Adjusted face-to-face contacts/Wk (LT 1/Wk)	2-14	9	3
13. Team provides Psychiatric Rehabilitation Services (LT 25% Vets)	2-15	6	6
<i>Client Outcome (Table 2_31)</i>			
14. Hospital Use: 365 Days % Change MH Days (Post-Pre Low)	2-18a	5	
15. Reported Symptoms: % Change (BSI) (High)	2-20	5	
16. Observed Symptoms: % Change (BPRS) (High)	2-19	5	
17. Quality of Life: % Change (QOL) (Low)	2-23	7	

MS#: Critical Performance Monitor is also a Minimum Standard (Table 2-32)

OUTLIER REVIEW REQUEST

(Provided by Email to each team with a critical monitor negative outlier value)

Outlier Review Instructions:

1. To streamline the outlier review process, I have send an e-mail message to each team with an outlier specific to the team's performance. Teams with outliers in the **undesired** direction need only: 1) Locate the outlier; 2) Check the data; 3) Select a reason for outlier status; 4) Give a brief explanation or plans to correct the team value; and 5) Email a completed copy back to me by Tuesday, April 25th.
2. **Next Steps:** Teams with negative outlier values in FY 2005 may want to consider adjusting team resources or operation to bring performance within the desired range for FY 2006. Teams with no outliers will be suitably rewarded.
3. **Note: Only negative (shaded) outliers for critical monitors indicated in the Outlier Summary Tables {Tables 2-27 through 2-31} require formal outlier response using the outlier review form you will receive by email.** Currently, this does not include outliers indicated for ACT Fidelity, Housing Independence, 6/12/18/24-month hospital use, IADLs, or Service Satisfaction. We have provided outlier feedback on these additional variables to assist your team in planning and to indicate areas where changes may be necessary to improve performance
4. If you have questions or comments about a particular measure or criterion value, or the review process, please contact me by phone: 203.932.5711x 2907 or Outlook at: Joseph.Castrodonatti@VA.Gov

Thank you very much!
Sincerely,

Joe Castrodonatti

SAMPLE Outlier Response Form (Varied with Outliers for each team)

Caseload Size Mean Ratio of Client/Clinical FTEE(GT 15)

- _____ a. Legitimate differences in this site's team that do not conflict with the national program goals.
- _____ b. Local policies at this site that may conflict with national program goals.
- _____ c. Problems in program implementation for which corrective action has been taken.
- _____ d. Problems in program implementation for which corrective action has since been planned
- _____ e. Problems in program implementation for which corrective action has not yet been planned

Explain: _____

List of MHICM Teams Included in the FY 2005 Performance Monitoring Report

VISN	Station Code	Facility Name
	STA5A	Location
1	518	Bedford
1	523A5	Brockton
1	402	Togus
1	689	West Haven
2	528A8	Albany
2	528	Buffalo
2	528A5	Canandaigua
2	528A7	Syracuse
3	630A4	Brooklyn
3	620	Hudson Valley
3	561A4	New Jersey
3	632	Northport
4	542	Coatesville
4	595	Lebanon
4	642	Philadelphia
4	646A5	Pittsburgh
5	512	Baltimore
5	613	Martinsburg
5	512A5	Perry Point
5	688	Washington, DC
6	558	Durham
6	565	Fayetteville
6	590	Hampton
6	658	Salem
6	659	Salisbury
7	508	Atlanta
7	509	Augusta
7	521	Birmingham
7	534	Charleston
7	544	Columbia
7	679	Tuscaloosa
7	619A4	Tuskegee
8	573	Gainesville
8	546	Miami
8	673	Tampa
8	548	West Palm Beach
9	603	Louisville
9	614	Memphis
9	626	Nashville
10	541GG	Akron
10	538	Chillicothe
10	539	Cincinnati
10	541	Cleveland
10	757	Columbus
10	552	Dayton
10	541GD	Mansfield
10	541B2	Youngstown

VISN	Station Code	Facility Name
	STA5A	Location
11	506	Ann Arbor
11	515	Battle Creek
11	550	Danville
11	553	Detroit
11	583	Indianapolis
11	610	Northern Indiana
12	537	Chicago-West Side
12	578	Hines
12	607	Madison
12	695	Milwaukee
12	556	North Chicago
12	676	Tomah
15	657A0	St. Louis
15	589A5	Topeka
16	520	Gulf Coast
16	580	Houston
16	598	Little Rock
16	629	New Orleans
17	549	Dallas
17	671	San Antonio
17	674A4	Waco
18	501	Albuquerque
18	644	Phoenix
18	678	Tucson
19	554	Denver
19	436	Fort Harrison
19	575	Grand Junction
19	660	Salt Lake City
19	666	Sheridan
19	567	Southern Colorado
20	663A4	American Lake
20	531	Boise
20	648	Portland
20	663	Seattle
21	640	Palo Alto
21	662	San Francisco
22	691	Greater Los Angeles
22	605	Loma Linda
22	600	Long Beach
22	664	San Diego
23	636A8	Iowa City
23	636A7	Knoxville
23	618	Minneapolis
23	636	Omaha
23	656	St. Cloud

Appendix D

Legend for MHICM Summary Report Tables

This appendix details the source and creation of variables included in national NEPEC monitoring of the 84 MHICM teams included in the 9th MHICM National Performance Monitoring Report for FY 2005. Site-by-site values for these variables are described in Chapter 2 of the report and presented in Tables 2-1 to 2-26, Figures 2-1 to 2-6 and Appendices E-H. Text and tables are organized into domains of program structure, client characteristics, service delivery, clinical outcomes and unit costs. Data for this report represent 5,696 veterans who received services and for whom follow-up data were available completed between October 1, 2004 and September 30, 2005.

Monitors for original MHICM teams are based on data for reduced numbers of recently entered clients and may not accurately represent values for their entire client population. For each variable, outliers were identified by tests of significance ($p < 0.05$) between the least square mean of the change score for a given team and the median site score. Outliers in undesired direction are indicated by **shaded** values and in the desired direction by **bold, underlined** values. Outliers are **boxed** in summary Tables 2-27 through 2-32. Team responses to outlier values are reported in Table 2-33. **Note: Seventy-one teams with 10 or more veterans who had Baseline (IDF) and Follow-up (FDF/CPR) data from “30 series” forms were included in analyses for this report.**

TO ASSIST WITH INTERPRETATION, SEE THE ACRONYM LIST AT THE END OF THIS APPENDIX

TABLE SUMMARY DATA (AT THE BOTTOM OF MOST TABLES)

ROW HEADING	COMPUTATION DESCRIPTION
ALL SITES	Overall sum or mean across all veterans for all MHICM teams included in the analysis.
SITE AVERAGE	Team mean or average for the 84 site values presented in the table above.
SITE STD. DEV.	Standard deviation from the mean for all site values presented in the table above.

Table 2-1: VA MHICM Program Monitors

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
Monitoring Domain	Area addressed by monitoring variable (Structure/Client/Process/Outcome/Cost).
Program Monitor	Monitoring variable derived from MHICM interviews, ratings, or centralized VA data.
Unit	Unit of measurement for monitoring variable.
Report Table	Number of report table presenting data on a given monitoring variable.
Program Objective	Program objective (1-6) addressed by monitoring variable (see Appendix B).
Critical Monitor	Indicator of critical status for comparison and outlier identification.

Table 2-2: MHICM Programs through FY 2005

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
VISN	Veterans Integrated Service Network number.
Site Name	Name/Location of host facility or healthcare system.
Site Code	Host Facility Station Code, including 5-digit station code numbers for consolidated facilities.
Site Type	GM&S: General Medical and Surgical facility; NP: Former Neuro-Psychiatric facility.
MHICM Startup Year	Year team began accepting veteran clients.

Table 2-3: Allocated Staff and Funds (Original Dollars)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: MHSHG Resource tables
Allocated FTE	Original allocation of positions for MHICM services (excludes local contributions).
Personal Service	Original allocation of recurring Personal Service funds (salary and benefits).
All Other	Original allocation of recurring All Other funds (supplies, leased equipment).
Admin. Support	Original allocation of recurring Administrative Support funds (use at local discretion).
Total Program \$	Original allocation of Total funds.
<u>Row Heading</u>	<u>Computation Description</u>
All Sites	Overall sum or mean across all individuals or MHICM teams included in the analysis.
Site Average	Team mean or average for the 84 site values presented in the table above.
Site S.D.	Standard deviation from the mean for all site values presented in the table above.

Table 2-4: FY 2005 Program Expenditures

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: FY 2005 site-generated progress reports.
FY 05 Filled FTE	FY 2005 reported MHICM filled FTE.
FY 05 P/S Expend.	FY 2005 reported expenditure of MHICM Personal Service funds.
FY 05 AO Expend.	FY 2005 reported expenditure of MHICM All Other funds.
FY 05 Total Expend.	FY 2005 reported Total expenditure of MHICM funds.

Table 2-5: Utilization of Staff Resources

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: September, 2005 Monthly FTE/Caseload Report
Allocated FTE	MHICM FTE ceiling, adjusted to include locally funded positions.
FY Filled FTE	MHICM positions reported filled as of September 30, 2005.
% FTE Utilized	Percent MHICM positions reported filled as of September 30, 2005.
Sept. Clinical FTE	Positions available to provide MHICM case management services as of September 30, 2005. Shaded values are below the MHICM standard of 4.0 Clinical FTEE.
FTE Unfilled GTE 6 mos.	Yes = one or more MHICM positions unfilled for 6 or more months. Shaded values had one or more positions unfilled for 6 months or more.
Assigned non-MHICM	Yes = one or more MHICM staff detailed to non-MHICM work. Shaded values have one or more staff detailed to non-MHICM work..

Table 2-6: Clinical Staff and Caseload

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: September, 2005 monthly FTE/Caseload Summary
Medical Support MD	Y = psychiatrist assigned to MHICM team. Shaded values indicate the team does not have an assigned psychiatrist.
Medical support RN	Y = nurse-case manager assigned to MHICM team. Shaded values indicate the team does not have an assigned nurse-case manager.
Clinical FTE	Positions available to provide MHICM case management services.
9/05 Total # Vets	MHICM veterans as of September 30, 2005.
9/05 Caseload / Clin FTE	Average number of veteran clients per clinical FTE. Shaded values indicate the mean caseload is outside MHICM standard range of 7:1 to 15:1.
Target Caseload	<u>Min</u> : minimum caseload ratio of 7 clients per clinical FTE (VHA Directive 2006-004). <u>Max</u> : maximum caseload ratio of 15 clients per clinical FTE (VHA Directive 2006-004).

Table 2-7: Demographic Characteristics of Veterans at Intake

<u>Column/Row Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Initial Data Form (IDF), Form 34.
Overall	All sites combined (N=84 teams in FY 2005 are represented in this report.)
GM&S	General medicine & surgery facilities (N=57 teams).
NP	Former neuro-psychiatric facilities (N=27 teams).
Gender	% MHICM veterans who are male or female (34: Face sheet).
Age	Mean age of MHICM veterans (34: Face).
Race	% MHICM veterans, from different racial/ethnic backgrounds (34: Face).
Marital status	% MHICM veterans with different marital histories (34: Face sheet).
Combat exposure	% MHICM veterans reporting exposure to combat (34: #25).
Employment Last 3 yrs	% MHICM veterans with different employment histories in past 3 years (34: #31).

Table 2-8: Entry Criteria Information

<u>Row Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: IDF 34.
Mn hospital days 1 yr pre	Mean days spent in VA hospital; year before entry (34: #17).
Inpt psych unit referral	% MHICM veterans referred for MHICM treatment directly from inpatient unit (34: #16).
Primary psych diagnosis	% MHICM veterans with a DSM-IV psychiatric diagnosis at entry (34: #21).
GTE 30 days in hospital	% MHICM veterans with 30+ psychiatric hospital days in year before entry (34: #17; PTF). <i>GTE means "Greater than or equal to."</i>
Dual diagnosis at entry	% MHICM veterans with co-morbid substance abuse diagnosis at entry (34: #21).
Diagnosis	% MHICM veterans meeting various diagnostic criteria at entry (34: #21).
Disability/Pension	% MHICM veterans receiving any compensation or disability funds (34: #26-9).
SC Disability	% MHICM veterans with VA service-connected disability (34: #26; Face).
NSC Pension	% MHICM veterans receiving VA non-service connected pension (34: #26; Face).
SSI	% MHICM veterans receiving Social Security Supplemental Income (34: #27).
SSDI	% MHICM veterans receiving Social Security Disability Income (34: #28).
Payee	% MHICM veterans with a designated representative payee for funds (34: #29).

Table 2-9: Receipt of Disability Compensation or Pension Income

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: IDF 34.
VA Compensation %	% MHICM veterans receiving VA service-connected compensation (34: #26).
NSC Pension %	% MHICM veterans receiving non-service-connected pension (34: #26).
SSI %	% MHICM veterans receiving Social Security Supplemental Income (34: #27).
SSDI %	% MHICM veterans receiving Social Security Disability Income (34: #28).
Rep Payee %	% MHICM veterans with a designated representative payee for funds (34: #29).
Any Disability %	% MHICM veterans receiving any compensation/disability pension (34: #26-29).

Table 2-10: Entry Criteria Information by Site

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: IDF 34.
Lifetime Hosp GT 2 yrs	% MHICM vets reporting lifetime psychiatric hospital use GT 2 yrs (34: #190).
Years since 1st Hosp	Mean years since first psychiatric hospitalization (34: #47).
GTE 30days Hosp. yr pre	% MHICM veterans with 30+ VA hospital days; year before entry (34: #17). Shaded values: Less than 50% of veterans have 30+ hospital days prior to entry. Bold values: 100% of veterans have 30+ hospital days in year prior to entry.
Psychotic Dx at Entry	% MHICM veterans with psychotic diagnosis at entry (34: #22), including: schizophrenia, schizo-affective disorder, other psychosis, and bipolar disorder. Shaded values: Less than 50% of veterans with diagnosis of psychosis at entry. Bold values: 100% of veterans have diagnosis of psychosis at entry.
Dual diagnosis	% MHICM veterans with co-morbid substance abuse diagnosis at entry (34: #21).

Table 2-11: Clinical Status at Entry

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Initial Data Form (IDF), Form 34.
Inpatient at Entry	% veterans entering MHICM from inpatient status (34: #16; 24: na).
Low IADL	% MHICM veterans scoring 1 or 2 on one of four Form 34 IADL items (#121,123-125).
BPRS Mean	Mean BPRS Total score (sum 18 items) at entry (34: #265-283). Note: "1" added to each BPRS item to conform with current reporting conventions.
GAF Mean	Average GAF score at entry (34: #284). Shaded values: Mean GAF score at entry is 50 or higher.

Table 2-12: MHICM Program Tenure

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Clinical Progress Report (CPR), Form 39; NEPEC Access files.
Total Vets	# MHICM veterans with FDF between 10/1/04 and 9/30/05 (Access/SAS).
Vets Discharged #	# Follow-up veterans discharged by program as of September 30, 2005 (Access).
Vets Discharged %	% Follow-up veterans discharged as of September 30, 2005 (#DC'd / Total # Vets). Shaded values: More than 20% of team veterans were discharged during the fiscal year.
Mean Days in Program	Average # Days in MHICM per veteran (FDF date minus IDF date).

Table 2-13: Pattern of Service Delivery

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Clinical Progress Report (CPR), Form 39; NEPEC Access files.
Total Vets	# MHICM veterans in FY 2005 (Access/SAS).
Contact Frequency	Face-to-face: % MHICM veterans with weekly or more frequent contact (39: #40). Telephone: % MHICM veterans with weekly or more frequent contact (39: #41).
Intensity	% MHICM veterans with GTE one hour of weekly contact (39: #45). Shaded values: Less than half of clients have weekly or more frequent contact. Bold values: More than 78% of clients have weekly or more frequent contact.
Location	% MHICM veterans with GTE 60% of contacts in the community (39: #37). Shaded values: Less than half of veterans have 60% or more of contact in the community. Bold values: 98-100% of clients have 60% or more of their contact in the community.
All Site v. Site Average	Mean value for all vets combined (N=5,696) v. site scores (N=84) in the table.

Table 2-14: Outpatient Clinic Visits

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: VA Outpatient Clinic (OPC) stops reported b/w 10/1/04 and 9/30/05.
Total Vets seen	# MHICM veterans with a MHICM stop code during FY 2005 (Access/SAS).
Mean contacts/Vet: 12mo.	Total: Avg. sum all MHICM encounters recorded under DSS identifiers 546 & 552 per vet. Telephone: Avg. sum telephone encounters recorded under DSS identifier 546 per vet. Face-Face: Avg. sum face-to-face encounters recorded under DSS identifier 552 per vet.
Amount time in program	Mean proportion of period (10/1/04-9/30/05) veterans spent in MHICM (per site). Used to standardize all veterans and sites at 12 months of program participation.
Adjusted face-face/vet	Mean face-to-face contacts, divided by team average amount of time in program.
Adjusted face-to-face contacts/wk/vet	Mean face-to-face contacts, adjusted for each teams amount of time in program, then divided by 52 weeks to get a contacts per week value. Shaded values: Mean of team contact is less than 1.0 per week per veteran. Bold values: Mean of team contact exceeds 1 standard deviation above the mean.

Table 2-15A & B: Therapeutic Services

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Clinical Progress Report (CPR), Form 39.
Follow-up Vets	# MHICM veterans with FDF between October 1, 2004 and September 30, 2005.
Supportive Contact	% veterans receiving supportive contact services from MHICM (39: # 13;).
Active Monitor	% veterans receiving active monitoring services from MHICM (39: #15).
Rehabilitation	% veterans receiving rehabilitation services from MHICM (39: #16).
	Shaded values: Less than 25% of veterans receive rehabilitation services.
	Bold values: Percent of clients receiving rehabilitation services exceeds 1 standard deviation above the mean.
Psychother Relationship	% veterans receiving psychotherapeutic treatment from MHICM (39: #18).
Social/Rec Activities	% veterans in social/recreational activities organized by MHICM (39: #19).
Crisis Intervent	% veterans receiving crisis intervention services from MHICM (39: #23).
Medicatrn Mgmt	% veterans whose medications were managed by MHICM (39: #24).
Medical Screen	% veterans screened for or treated for medical problems by MHICM (39: #25).
Seen for Sub. Abuse	% veterans receiving substance abuse treatment from MHICM (39: #26).
Housing Support	% veterans assisted with locating or managing housing by MHICM (39: #27).
Vocational Support	% veterans assisted with locating or maintaining a job by MHICM (39: #30).

Table 2-16: Client-Rated Therapeutic Alliance

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	IDF 34; Follow-up Data Form (FDF), Form 37.
	MHICM alliance at 6 mos. was compared with pre-entry alliance with primary clinician.
Pre-Entry N	MHICM veterans with IDF entry interview data on this measure.
Pre-Entry Mean	Average score for this measure at entry (34: #219-225).
Follow-up Mean	Average score for this measure at 6 months (37: #179-185), adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
	Shaded values: Adjusted change value is significantly lower (p<0.05) than median site.
	Bold values: Adjusted change value is significantly higher (P<0.05) than median site.
Percent Change	Change at Follow-up divided by Pre-Entry Mean to get adjusted percent change.

Table 2-17: Fidelity to Assertive Community Treatment Model

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	DACTS self-report by sites; confirmed with other available data.
Human Resources	Average program score on 7 human resources items.
Organiz'l Boundaries	Average program score on 7 organizational boundaries items.
Services	Average program score on 6 nature of services items.
Sub.Abuse Tx	Average program score on 3 substance abuse treatment items.
Total Score	Total program score: sum of 23 DACTS items.
Avg. Score	Average program score: mean of 23 DACTS items. Original DACTS contains 26 items.
	Compare VA scores to averages, NOT to totals, for non-VA programs.
	Shaded values exceed 1 standard deviation below the mean site (undesired).
	Bold values exceed 1 standard deviation above the mean site (desired).

Table 2-18: VA Hospital Use: 183 Days Before and After Program Entry

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: PTF through 9/30/05.
Total N FY 05	# MHICM veterans as of 9/30/05.
N 183 Days	# MHICM veterans with 183 or more days in program (entered by 3/31/05).
Pre-Entry MH Days/Vet	Mean mental health hospital days per veteran in 183 days before MHICM entry.
Post-Entry MH Days/Vet	Mean mental health hospital days per veteran in 183 days after MHICM entry.
Change MH Days/Vet	Mean change in mental health hospital days (Post- minus pre-MHICM entry).
	Shaded values exceed 1 standard deviation from mean in direction of fewer days/lower %.
	Bold values exceed 1 standard deviation from mean in direction of more days/higher %.
% Change MH Days/Vet	Mean % change in mental health days (Change MH Days/Pre-IDF MH Days).
Inp't MH Per Diem FY05	Mean national inpatient mental health per diem cost (NMHPPMS): \$1,011 [hidden col.]
Change IP MH Cost/Vet	183-day Inpatient MH reduction per MHICM vet (Input MH Per Diem x Change MH Days).
	Cost change data are unadjusted for inflation and do not fully represent cost reductions achieved for veterans at original MHICM sites.

Table 2-18a: VA Hospital Use: 365 Days Before and After Program Entry**Table 2-18b: VA Hospital Use: 548 Days Before and After Program Entry****Table 2-18c: VA Hospital Use: 730 Days Before and After Program Entry**

The format for these Tables is identical to that for Table 2-18, with increasing Pre- and Post-Entry time frames: a) 365 days; b) 548 days; and c) 730 days. For each table, data are reported only for veterans with sufficient time in the program to allow that Pre-Post comparison. **Program entry is defined by Initial Data Form (IDF) completion date.**

Table 2-19: Brief Psychiatric Rating Scale (Observed symptoms)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	IDF 34; Follow-up Data form (FDF), Form 37.
	Note: "1" added to each BPRS item to conform with current reporting conventions.
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Mean	Mean BPRS Total score (sum 18 items) at entry (34: #265-283).
Follow-up Mean	Mean BPRS Total score (sum 18 items) at follow-up (37: #225-243), adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change.
	Shaded values: Adjusted change value is significantly higher (p<0.05) than median site.
	Bold values: Adjusted change value is significantly lower (P<0.05) than median site.

Table 2-20: Symptom Severity (Client-reported Brief Symptom Inventory Items)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	IDF 34; FDF 37 Schizophrenia Outcomes Module & Brief Symptom Inventory items (Note: Replication site variables are scaled differently and not included.)
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Mean	Mean symptom score at entry (34: #51-80).
Follow-up Mean	Mean symptom score at follow-up (37: #30-59), adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change.
	Shaded values: Adjusted change value is significantly higher (p<0.05) than median site.
	Bold values: Adjusted change value is significantly lower (P<0.05) than median site.

Table 2-21: Global Assessment of Functioning (GAF; DSM-IV Axis V)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	IDF 34; FDF 37.
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Mean	GAF score at entry (34: #284).
Follow-up Mean	Mean GAF score at follow-up (39: #116) adjusted for site, time in program, baseline value, and 11 baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower (p<0.05) than median site. Bold values: Adjusted change value is significantly higher (P<0.05) than median site.

Table 2-22: Instrumental Activities of Daily Living (Schizophrenia Outcomes Module items)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	IDF 34; FDF 37.
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Mean	Mean IADL score at entry (34: # 114-125).
Follow-up Mean	Mean IADL (37: #77-88) score at follow-up adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower (p<0.05) than median site. Bold values: Adjusted change value is significantly higher (P<0.05) than median site.

Table 2-23: Quality of Life (Lehman QOLI Delighted-Terrible items)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	IDF 34; FDF 37.
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Mean	Mean QOL scores at entry (34: #23,128,136,147,150,240).
Follow-up Mean	Mean QOL scores (37: #14,91,99,110,113,201) adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower (p<0.05) than median site. Bold values: Adjusted change value is significantly higher (P<0.05) than median site.

Table 2-23a: Housing Independence Index (NEPEC scale)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	IDF 34; FDF 37: Days in each setting were multiplied by weight for restrictiveness.
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Sum	Sum of weighted HOUI items at entry (34: #138*4, 140*3, 142*2, 144*1, 146*0).
Follow-up Sum	Sum of weighted HOUI items at follow-up (37: #101*4, 103*3, 105*2, 107*1, 109*0) adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower (p<0.05) than median site. Bold values: Adjusted change value is significantly higher (P<0.05) than median site.

Table 2-24: VA Mental Health Services Satisfaction (3 item)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	IDF 34; FDF 37.
Pre-Entry N	MHICM veterans with entry interview data on VA Mental Health services satisfaction.
Pre-Entry Mean	Sum VA MH Satisfaction score at entry (34: #232,235,239).
Follow-up Mean	Sum VA MH Satisfaction score at follow-up (37: #193,196,200) adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower (p<0.05) than median site. Bold values: Adjusted change value is significantly higher (P<0.05) than median site.

Table 2-25: Satisfaction with VA MHICM Services (vs. VA Mental Health Services; single items)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	FDF 37.
Pre-Entry N	MHICM veterans with entry interview data on VA mental health services satisfaction.
Pre-Entry Mean	Mean VA MH services satisfaction score at entry (34: #228).
Follow-up Mean	Mean MHICM Satisfaction score at follow-up (37: #190) adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower (p<0.05) than median site. Bold values: Adjusted change value is significantly higher (P<0.05) than median site.

Table 2-26: MHICM Unit Costs (per Veteran, FTE, Visit)

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: FY 2005 Site-generated annual progress reports, OPC stop codes.
FY05 Total Expenditures	FY 2005 reported total expenditure of MHICM funds.
Total Vets	# MHICM veterans receiving MHICM services in FY 2005 (OPC).
Cost per Veteran	Annual cost per MHICM veteran (FY 05 Total Expenditures divided by Total Vets)
FY05 P/S Expenditures	FY 2005 reported personal service expenditures.
FY05 Filled FTE	MHICM positions reported filled as of September 30, 2005.
Cost per FTE	Annual cost per MHICM FTE (FY 05 P/S Expenditures divided by Total FTE)
Adj. Total Visits/Vet/Yr	Total MHICM stop code visits (per veteran), adjusted for 52 weeks.
Total Visits/Site/Yr	Adjusted Total Visits/Vet/Yr multiplied by Total Vets to get Total Team Visits for FY 2005.
Cost per Visit	Cost per visit (FY 05 Total Expenditures divided by Total Visits per Yr)

Table 2-27: Site Performance on MHICM Critical Monitors

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Critical monitor outliers identified on tables 2-1 to 2-24.
Structure	# of 5 critical monitors in tables 2-2 to 2-6 in undesired direction.
Client	# of 3 critical monitors in tables 2-7 to 2-11 in undesired direction.
Process	# of 5 critical monitors in tables 2-12 to 2-17 in undesired direction.
Outcome	# of 4 critical monitors in tables 2-18 to 2-25 in undesired direction.
Site Total	Total # of 17 critical monitors in tables 2-2 to 2-25 in undesired direction.

Table 2-28: Outliers for Team Structure Monitors

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Outliers from Tables 2-5 and 2-6.
FTE Unfilled	Yes = one or more MHICM positions unfilled for 6 or more months (Table 2-5).
Unassigned Medical Caseload Size	N = physician (MD) or nurse-case manager (RN) <u>not</u> assigned to MHICM team (2-6).
Team Size	Total # MHICM veterans as of 9/30/05 divided by Clinical FTE as of 9/30/05 (2-6).
Total Team Outliers	Clinical FTE as of September 30, 2005 (Monthly FTE/Caseload Report) (2-5).
# Applicable Monitors	# Team Structure monitors for which team value is an outlier (range: 0-5).
% Outliers/Applicable	# Team Structure monitors that applied to team in FY 2005 (range: 0-5).
	# team outliers divided by # applicable monitors.

Table 2-29: Outliers for Client Characteristics Monitors

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Outliers from Tables 2-10 and 2-11.
% Clients GTE 30 Days	% MHICM veterans with 30+ VA hospital days in year before entry (2-10).
% Clients Psychotic Dx	% MHICM veterans with psychotic diagnosis at entry (2-10).
Mean GAF at Entry	Average GAF score at entry for veterans seen by team (2-11).
Total Team Outliers	# Client Characteristics monitors for which team value is an outlier (range: 0-3).
# Applicable Monitors	# Client Characteristics monitors that applied to team in FY 2005 (range: 0-3).
% Outliers/Applicable	# team outliers divided by # applicable monitors.

Table 2-30: Outliers for Clinical Process Monitors

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Outliers from Tables 2-12, 2-13, 2-14 and 2-15.
Tenure	% veterans discharged as of September 30, 2005 (2-12).
Intensity	% veterans with one hour or more of weekly contact (2-13).
Location	% veterans with 60% or more of contacts in the community (2-13).
Frequency # Adjusted	Mean face-to-face visits, adjusted for each teams amount of time in program, then divided by 52 weeks to get a visits per week value (2-14).
Team provides...Rehab	% veterans receiving rehabilitation services from MHICM team (2-15A).
Total Team Outliers	# Clinical Process monitors for which team value is an outlier (range: 0-5).
# Applicable Monitors	# Clinical Process monitors that applied to team in FY 2005 (range: 0-5).
% Outliers/Applicable	# team outliers divided by # applicable monitors.

Table 2-31: Outliers for Client Outcome Monitors

<u>Column Heading</u>	<u>Source/Variable and Computation Description</u>
	Source: Outliers from Tables 2-18a, 2-19, 2-20 and 2-23.
365 Days % Change	Mean % change in mental health days after 365 days (2-18a).
Reported Symptoms %	Change in BSI at Follow-up (2-20).
Observed Symptoms %	Change in BPRS at Follow-up (2-19).
Quality of Life %	Change in QOL at Follow-up (2-23).

Table 2-32A&B: Outliers for Minimum Standards

	Source: Selected Outliers from Tables 2-5, 2-6, 2-10, 2-12, 2-13, 2-14, and 2-15.
% Clients Psychotic Dx	% vets with psychotic diagnosis at entry (<i>Threshold: 50% or more</i>) (2-10).
% Clients GTE 30 Days	% vets with 30+ psychiatric inpatient days in year pre-entry (<i>50% or more</i>)(2-10).
# Adjusted Face-to-face	Mean adjusted face-to-face visits per week per veteran (<i>1.0 or more</i>)(2-14).
Caseload Size	Ratio of veterans to clinical FTE (mean caseload as of 9/30/01)(<i>7:1 to 15:1</i>) (2-6).
% Clients seen 60%...	% vets for whom 60+% of visits occur in community (<i>50% or more</i>) (2-13).+
Team provides...Rehab	% vets receiving psychiatric rehabilitation/skills training (<i>25% or more</i>) (2-15).
Tenure	% vets discharged from MHICM program in FY 2005 (<i>< 20%</i>) (2-12).
Team Size	# Clinical case managers on team as of 9/30/05 (<i>4.0+ FTEE</i>) (2-5).
Total Outliers	# of 8 minimum standards for which team value was an outlier (range: 0-8).
% Min Stand Outliers	% of 8 minimum standards for which team value was outlier in FY 2005.
% Outliers FY 2001	% of 8 minimum standards for which team value was outlier in FY 2001.
Change % Outliers	Change in team % outliers from FY 2001 to FY 2005.

Table 2-33 Site Outlier Review Summary

	Source: Site completed Outlier Review Forms for indicated outliers.
Site # Outliers	# of critical monitors for which team value was an outlier in undesired direction.
Reason A	# Team responses indicating “Legitimate differences in this site’s team that do not conflict with national program goals”.
Reason B	# Team responses indicating “Local policies at this site that may conflict with national program goals”.
Reason C	# Team responses indicating “Problems in program implementation for which corrective action has been taken”.
Reason D	# Team responses indicating “Problems in program implementation for which corrective action has since been planned”.
Reason E	# Team responses indicating “Problems in program implementation for which corrective action has not yet been planned”.
Sum of Responses	# outliers addressed in Outlier Review.

Appendix E. MHICM Case Management Services, FY 2005 (MHICM Veterans)**Source: VA Outpatient Clinic File (Austin, TX).**

MHICM Community	Visits recorded under DSS Identifier (stop code) #552, MHICM.
# Veterans	Number of veterans with at least one MHICM visit.
# Visits	Total MHICM (stop code 552) visits.
Mn Visits	Mean number of MHICM visits per veteran with at least one visit.
Low Intensity CM Visits	Visits recorded under DSS Identifier #564, General Case Management.
# Veterans	Number of veterans with at least one Low Intensity or General CM visit.
#Visits	Total Low Intensity or General CM (stop code 564) visits.
Mn Visits	Mean number of Low Intensity visits per veteran with at least one visit.
Facility Sum/Mean	Total number of veterans and overall mean of visits across all facilities.
VISN Sum/Mean	Total number of veterans and overall mean of visits across all VISNs.

Appendix F. Non-MHICM Case Management Services, FY 2005 (Non-MHICM Veterans)**Source: VA Outpatient Clinic File (Austin, TX).**

MHICM Community	Visits recorded under DSS Identifier (stop code) #552, MHICM.
Veterans (N)	Number of veterans with at least one MHICM visit.
# Visits	Total MHICM (stop code 552) visits.
Mn Visits	Mean number of MHICM visits per veteran with at least one visit.
General CM Visits	Visits recorded under DSS Identifier #564, General Case Management.
Veterans (N)	Number of veterans with at least one General/Low Intensity CM visit.
#Visits	Total General/Low Intensity (stop code 564) visits.
Mn Visits	Mean number of Low Intensity visits per veteran with at least one visit.
Facility Sum/Mean	Total number of veterans and overall mean of visits across all facilities.
VISN Sum/Mean	Total number of veterans and overall mean of visits across all VISNs.

Appendix G. MHICM Complex VERA Veterans, FY 2005**Source: Allocation Resource Center; NEPEC Monitoring Files.**

MHICM Vets	Veterans registered in MHICM program during FY 2005.
Complex VERA Vets #	Veterans identified by ARC with 41 or more MHICM stop Code 552 Visits in FY 05. Note: Additional veterans may have previously qualified for complex class status in other patient classes (e.g. chronic mental illness) based on prior VA service use or retention criteria.
Complex VERA Vets %	Percentage of MHICM registered veterans identified as MHICM Complex VERA Class.

Appendix H. MHICM Program Monitor Trends, FY 1997-2005

Source: MHICM Performance Monitoring Reports, FY 1997-2005.

FY 1997 - FY 2005 values are presented for select MHICM performance monitors, by monitoring domain, along with the percent change in values between 1997-2005.

Team Structure

Teams	Total MHICM teams in FY 2005 (84 teams included in FY 2005 Report).
Clients	Total veteran clients included in FY 2005 report.
Expenditure	Total program expenditures for 84 MHICM teams in FY 2005 report.
Assigned FTEE	Total FTE assigned to 84 MHICM teams in the FY 2005 report.
Filled FTEE	Total filled FTEE for 84 MHICM teams in FY 2005 report.
% Filled	Filled FTEE divided by assigned FTE.
Staff detailed away	% of filled FTE detailed part-time to other services.
Cost/Client	Unit cost per MHICM client
Client/Staff ratio	Mean client to staff ratio (caseload size). MHICM range: 7:1 to 15:1.

Client Characteristics

Age	Mean client age at entry.
Minority race / ethnicity	Percent minority race / ethnicity.
Mean hospital days yr pre	Mean hospital days per veteran in year preceding entry.
% 30+ hospital days yr pre	Percent of clients meeting minimum hospital days criterion at entry: 30+ days in prior year.
2+ yrs hospital lifetime	Percent of clients with 2 or more years of total lifetime psychiatric hospitalization.
Psychotic diagnosis	Percent clients with a primary psychiatric diagnosis with psychosis at entry.
Substance use diagnosis	Percent of clients with co-occurring substance use diagnosis at entry.
Paid employment (3yrs)	Percent of clients reporting paid employment in the three years preceding entry.
Public support income	Percent of clients receiving public support income from VA or social security at entry.

MHICM Services

Contacted weekly	Percent of clients contacted weekly or more frequently.
Contacts/week	Face-to-face contacts per week adjusted for portion of year in program.
60%+ visits community	Percent of clients with 60% or more of contacts occurring in the community.
Discharged	Percent of MHICM clients discharged during FY 2005.
Client-rated Alliance	Therapeutic alliance score reported by MHICM clients at follow-up
Team ACT Fidelity Score	Mean ACT fidelity score for MHICM teams overall.

Client Outcome (Follow-up)

Observed symptoms	Percent change in BPRS score from entry to follow-up.
Reported symptoms	Percent change in BSI score from entry to follow-up.
Quality of Life reported	Percent change in Quality of Life score from entry to follow-up.
Satisfaction MHICM (1-5)	Percent change in Client Satisfaction with MHICM at follow-up.
Change Inpt days (6mos.)	Change in psychiatric hospital days during first 6 months.
% Change Inpt days (6mo)	Percent change in psychiatric hospital days during first 6 months.

Acronyms

ACCESS	MICROSOFT OFFICE RELATIONAL DATABASE SOFTWARE
ACT	ASSERTIVE COMMUNITY TREATMENT (PROGRAM MODEL)
ADJ	ADJUSTED SCORE
AVG/MN	AVERAGE
ARC	ALLOCATION RESOURCE CENTER
BPRS	BRIEF PSYCHIATRIC RATING SCALE
BSI	BRIEF SYMPTOM INVENTORY
CM	CASE MANAGEMENT OR CASE MANAGER
CPR	CLINICAL PROGRESS REPORT FORM (NEPEC MONITORING FORM 39)
DSS	DECISION SUPPORT SYSTEM (VHA FISCAL SOFTWARE)
DX	DIAGNOSIS
FDF	FOLLOW-UP DATA FORM (NEPEC MONITORING FORM 37)
FTE	FULL TIME EQUIVALENT POSITION
FY	FISCAL YEAR
GAF	GLOBAL ASSESSMENT OF FUNCTIONING SCORE
GM+S	GENERAL MEDICINE AND SURGERY FACILITY
GTE	GREATER THAN OR EQUAL TO
HOU1	HOUSING INDEPENDENCE INDEX
IADL	INSTRUMENTAL ACTIVITIES OF DAILY LIVING
IDF	INITIAL DATA FORM (NEPEC MONITORING FORM 34)
IDF DATE	INITIAL DATA FORM DATE
IP	INPATIENT
MAX	MAXIMUM
MD	PHYSICIAN, PSYCHIATRIST
MH	MENTAL HEALTH
MHICM	MENTAL HEALTH INTENSIVE CASE MANAGEMENT (PROGRAM)
MIN	MINIMUM
NEPEC	NORTHEAST PROGRAM EVALUATION CENTER (WEST HAVEN, CONNECTICUT)
NP	FORMER NEUROPSYCHIATRIC FACILITY
NSC	NON-SERVICE-CONNECTED
OMHS	OFFICE OF MENTAL HEALTH SERVICES
OPC	OUTPATIENT CLINIC FILE (VHA OUTPATIENT AUTOMATED DATA, AUSTIN TX)
OQP	OFFICE OF QUALITY AND PERFORMANCE
PTF	PATIENT TREATMENT FILE (VHA INPATIENT AUTOMATED DATA, AUSTIN TX)
PRE-ENTRY	PERIOD BEFORE ADMISSION TO MHICM
QOL	QUALITY OF LIFE SCALE
RN	NURSE
SAS	STATISTICAL ANALYSIS SYSTEM SOFTWARE
SC	SERVICE-CONNECTED
SMI	SERIOUS MENTAL ILLNESS
SMITREC	SERIOUS MENTAL ILLNESS TREATMENT RESEARCH EVALUATION CENTER
SSI	SOCIAL SECURITY SUPPLEMENTAL INCOME
SSDI	SOCIAL SECURITY DISABILITY INCOME
TX	TREATMENT
YR	YEAR
VERA	VETERANS EQUITABLE RESOURCE ALLOCATION (VA BUDGETING STRUCTURE)
VHA	VETERANS HEALTH ADMINISTRATION
VHACO	VETERANS HEALTH ADMINISTRATION CENTRAL OFFICE
VISN	VETERANS INTEGRATED SERVICE NETWORK (MULTI-SITE HEALTH SYSTEM)
VSSC	VHA SUPPORT SERVICE CENTER

Appendix E
MHICM Case Management Services, FY 2005 (Registered MHICM Veterans*)

			MHICM Visits (Stop Code 552 Visits)				General CM Visits (Stop Code 564 Visits)		
SITE			Veterans	Veterans~	Visits	Visits	Veterans	Visits	Visits
VISN CODE	SITE NAME/VISN		#Total	#Low (9/30)	#	Mean	#	#	Mean
1 518	BEDFORD		133	2	10,086	75.8	0	0	0.0
1 523A5	BROCKTON		80	1	3,647	45.6	0	0	0.0
1 402	TOGUS		35	6	1,736	49.6	0	0	0.0
1 689	WEST HAVEN		67	0	4,690	70.0	1	4	4.0
	VISN 1		315	9	20,159	60.3	1	4	1.0
2 528A8	ALBANY		52	6	4,654	89.5	0	0	0.0
2 528	BUFFALO		83	0	2,957	35.6	0	0	0.0
2 528A5	CANANDAIGUA		97	0	7,613	78.5	0	0	0.0
2 528A7	SYRACUSE		48	5	2,290	47.7	0	0	0.0
	VISN 2		280	11	17,514	62.8	0	0	0.0
3 630A4	BROOKLYN		60	5	1,820	30.3	1	1	1.0
3 620	HUDSON VALLEY		84	0	5,305	63.2	0	0	0.0
3 561	NEW JERSEY		94	8	4,707	50.1	3	39	13.0
3 632	NORTHPORT		112	14	5,068	45.3	6	6	1.0
	VISN 3		350	27	16,900	47.2	10	46	3.8
4 542	COATESVILLE		101	3	5,907	58.5	20	130	6.5
4 595	LEBANON		20	0	1,080	54.0	15	95	6.3
4 642	PHILADELPHIA		32	0	2,019	63.1	2	2	1.0
4 646A5	PITTSBURGH		130	5	4,592	35.3	0	0	0.0
	VISN 4		283	8	13,598	52.7	37	227	3.5
5 512	BALTIMORE		26	0	1,147	44.1	0	0	0.0
5 613	MARTINSBURG		49	0	1,947	38.9	0	0	0.0
5 512A5	PERRY POINT		69	7	4,450	64.5	0	0	0.0
5 688	WASHINGTON, DC		49	0	1,810	36.9			
	VISN 5		193	7	9,354	46.1	0	0	0.0
6 565	FAYETTEVILLE		35	0	1,923	54.9	0	0	0.0
6 590	HAMPTON		61	8	4,463	73.2	1	4	4.0
6 658	SALEM		29	1	1,086	37.5	5	8	1.6
6 659	SALISBURY		60	1	1,931	32.2	0	0	0.0
	VISN 6		185	10	9,403	49.4	6	12	1.4
7 508	ATLANTA		67	19	4,439	66.3	0	0	0.0
7 509	AUGUSTA		76	2	4,637	61.0	0	0	0.0
7 521	BIRMINGHAM		39	0	3,064	78.6	0	0	0.0
7 534	CHARLESTON		35	0	2,127	60.8	0	0	0.0
7 544	COLUMBIA, SC		55	9	1,910	34.7	0	0	0.0
7 679	TUSCALOOSA		73	4	4,571	62.6	0	0	0.0
7 619A4	TUSKEGEE		60	15	3,136	52.3	0	0	0.0
	VISN 7		405	49	23,884	59.5	0	0	0.0
8 573	GAINESVILLE		57	3	4,437	77.8	0	0	0.0
8 546	MIAMI		85	26	4,224	49.7	0	0	0.0
8 673	TAMPA		52	6	2,614	50.3	0	0	0.0
8 548	WEST PALM BEACH		24	0	1,156	48.2	0	0	0.0
	VISN 8		218	35	12,431	56.5	0	0	0.0
10 541GG	AKRON		43	5	2,597	60.4	1	1	1.0
10 538	CHILLICOTHE		110	0	5,269	47.9	1	2	2.0
10 539	CINCINNATI		142	0	5,695	40.1	0	0	0.0
10 541	CLEVELAND		139	16	7,896	56.8	0	0	0.0
10 757	COLUMBUS		29	2	1,789	61.7	0	0	0.0
10 552	DAYTON		122	0	6,013	49.3	0	0	0.0
10 541GD	MANSFIELD		38	3	2,535	66.7	5	7	1.4
10 541B2	YOUNGSTOWN		44	1	3,005	68.3	0	0	0.0
	VISN 10		667	27	34,799	56.4	7	10	0.6

SITE			MHICM Visits				General CM Visits		
			(Stop Code 552 Visits)				(Stop Code 564 Visits)		
VISN CODE	SITE NAME/VISN	Veterans #Total	Veterans~ #Low (9/30)	Visits #	Visits Mean	Veterans #	Visits #	Visits Mean	
11 506	ANN ARBOR HCS	53	1	3,598	67.9	0	0	0.0	
11 515	BATTLE CREEK	78	12	4,120	52.8	38	183	4.8	
11 550	DANVILLE	41	0	3,845	93.8	0	0	0.0	
11 553	DETROIT VAMC	86	18	3,015	35.1	0	0	0.0	
11 610	NORTHERN INDIANA	83	10	6,127	73.8	2	3	1.5	
	VISN 11	341	41	20,705	64.7	40	186	1.3	
12 537	CHICAGO WEST SIDE	69	2	4,579	66.4	0	0	0.0	
12 607	MADISON	50	0	7,261	145.2	0	0	0.0	
12 695	MILWAUKEE	53	0	2,521	47.6	0	0	0.0	
12 556	NORTH CHICAGO	133	11	10,864	81.7	0	0	0.0	
12 676	TOMAH,WI	51	0	5,470	107.3	0	0	0.0	
	VISN 12	356	13	30,695	89.6	0	0	0.0	
15 657A0	ST.LOUIS,MO	66	1	2,587	39.2	0	0	0.0	
15 589A5	TOPEKA	101	2	10,876	107.7	6	8	1.3	
	VISN 15	167	3	13,463	73.4	6	8	0.7	
16 520	GULF COAST	51	4	2,166	42.5	0	0	0.0	
16 580	HOUSTON	67	0	2,851	42.6	0	0	0.0	
16 598	LITTLE ROCK	56	0	3,918	70.0	48	718	15.0	
16 629	NEW ORLEANS	55	1	1,848	33.6	0	0	0.0	
	VISN 16	229	5	10,783	47.1	48	718	3.7	
17 549	DALLAS	80	26	5,304	66.3	0	0	0.0	
17 671	SAN ANTONIO	36	0	2,580	71.7	0	0	0.0	
17 685	WACO	62	0	3,910	63.1	0	0	0.0	
	VISN 17	178	26	11,794	67.0	0	0	0.0	
18 501	ALBUQUERQUE	70	0	5,948	85.0	0	0	0.0	
18 644	PHOENIX	97	6	3,351	34.6	1	1	1.0	
	VISN 18	167	6	9,299	59.8	1	1	0.5	
19 554	DENVER	73	10	3,360	46.0	0	0	0.0	
19 575	GRAND JUNCTION	44	7	2,546	57.9	0	0	0.0	
19 660	SALT LAKE CITY	71	10	4,114	57.9	1	1	1.0	
19 666	SHERIDAN	18	0	727	40.4	0	0	0.0	
19 567	SOUTHERN COLORADO	86	0	5,210	60.6	1	1	1.0	
	VISN19	292	27	15,957	52.6	2	2	0.4	
20 663A4	AMERICAN LAKE	54	0	2,451	45.4	0	0	0.0	
20 531	BOISE	39	0	828	21.2	0	0	0.0	
20 648	PORTLAND	78	0	5,218	66.9	8	61	7.6	
20 663	SEATTLE	59	11	2,429	41.2	0	0	0.0	
	VISN 20	230	11	10,926	43.7	8	61	1.9	
21 640	PALO ALTO	73	6	3,147	43.1	0	0	0.0	
21 662	SAN FRANCISCO	46	1	2,892	62.9	0	0	0.0	
	VISN 21	119	7	6,039	53.0	0	0	0.0	
22 691	GREATER LOS ANGELES	61	1	2812	46.1	0	0	0.0	
22 664	SAN DIEGO	75	4	3309	44.1	0	0	0.0	
	VISN 22	136	5	6,121	45.1	0	0	0.0	
23 636A8	IOWA CITY,IA	49	0	2,208	45.1	0	0	0.0	
23 636A7	KNOXVILLE	86	9	4,609	53.6	1	18	18.0	
23 618	MINNEAPOLIS	71	21	3,349	47.2	1	1	1.0	
23 636	OMAHA,NE	47	0	2,224	47.3	0	0	0.0	
23 656	ST.CLOUD	33	1	1,265	38.3	2	7	3.5	
	VISN 23	286	31	13,655	46.3	4	26	4.5	
Facility Sum		5,397	358	307,479	57.0	170	1,301	7.7	
VISN Mean		270	18	15,374	56.7	9	65	1.2	
Standard Deviation		119.9	13.4	7405.1	11.0	14.4	161.8	1.5	
Coefficient of Variation		0.4	0.7	0.5	0.2	1.7	2.5	1.3	

* MHICM teams submitted Initial Data Forms and Follow-up monitoring data for these veterans to NEPEC.

~ MHICM veterans identified as receiving general case management services on 9/30/05.

Appendix F
Non-MHICM Case Management Services, FY 2005
(Non-MHICM Veterans at MHICM and Non-MHICM Sites~)

SITE			MHICM Visits (Stop Code 552)			General CM Visits (Stop Code 564)		
VISN	CODE	SITE NAME	#Veterans	#Visits	MnVisits	#Veterans	#Visits	MnVisits
1	402	TOGUS*	4	71	17.8	0	0	0.0
1	518	BEDFORD*	55	163	3.0	0	0	0.0
1	523A5	BROCKTON VAMC*	13	124	9.5	0	0	0.0
1	523GB	WORCESTER CBOC MA	2	2	1.0	0	0	0.0
1	689	WEST HAVEN*	2	78	39.0	0	0	0.0
		VISN 1	76	438	5.8	0	0	0.0
2	528	UPSTATE N.Y. HCS*	44	218	5.0	0	0	0.0
2	528A4	BATAVIA DIVISION				0	0	0.0
2	528A5	CANANDAIGUA DIVISION*	88	3453	39.2	0	0	0.0
2	528A7	HCS UPSTATE NY V2 SYRACUSE*	23	137	6.0	0	0	0.0
2	528A8	HCS UPSTATE NY V2 ALBANY*	18	33	1.8	0	0	0.0
2	528GE	ROCHESTER CBOC UPS NY	1	1	1.0	0	0	0.0
		VISN 2	174	3,842	22.1	0	0	0.0
3	526	BRONX#	156	433	2.8	0	0	0.0
3	561A4	LYONS*	40	126	3.2	3	50	16.7
3	561BY	NEWARK-SOC	3	6	2.0	37	461	12.5
3	620	HUDSON VALLEY*	36	332	9.2	81	862	10.6
3	620A4	CASTLE PNT VA HUDSON HCS NY	9	14	1.6	6	42	7.0
3	620GA	NEW CITY (ROCKLAND) CBOC				98	277	2.8
3	630GC	BROOKLYN CBOC	11	39	3.5	0	0	0.0
3	632	NORTHPORT*	17	95	5.6	14	28	2.0
		VISN 3	272	1,045	3.8	239	1,720	7.2
4	540	CLARKSBURG	14	84	6.0	0	0	0.0
4	542	COATESVILLE*	63	330	5.2	138	1,234	8.9
4	595	LEBANON*	10	289	28.9	17	81	4.8
4	642	PHILADELPHIA (OLD)*	51	107	2.1	3	7	2.3
4	646A5	PITTSBURGH-HIGHLAND DR*	15	179	11.9	0	0	0.0
4	693	WILKES BARRE	28	305	10.9	0	0	0.0
4	693B4	ALLENTOWN-SOC				0	0	0.0
		VISN 4	181	1,294	7.1	158	1,322	8.4
5	512	BALTIMORE*	19	92	4.8	0	0	0.0
5	512A5	PERRY POINT*	18	100	5.6	0	0	0.0
5	613	MARTINSBURG*	14	61	4.4	0	0	0.0
5	688	WASHINGTON DC*	96	155	1.6	0	0	0.0
		VISN 5	147	408	2.8	0	0	0.0
6	558	DURHAM*	6	12	2.0	20	130	6.5
6	565	FAYETTEVILLE NC*	10	24	2.4	0	0	0.0
6	590	HAMPTON*	33	109	3.3	0	0	0.0
6	637	ASHEVILLE-OTTEEN				112	545	4.9
6	658	SALEM*	7	36	5.1	192	391	2.0
6	659	SALISBURY*	9	19	2.1	7	8	1.1
6	659GA	CHARLOTTE CBOC				2	2	1.0
		VISN 6	65	200	3.1	333	1,076	3.2
7	508	ATLANTA*	10	46	4.6	0	0	0.0
7	509A0	LENWOOD	17	34	2.0	0	0	0.0
7	521	BIRMINGHAM*	12	39	3.3	0	0	0.0
7	534	CHARLESTON*	2	53	26.5	0	0	0.0
7	544	COLUMBIA SC*	28	277	9.9	0	0	0.0
7	619	MONTGOMERY	1	1	1.0	0	0	0.0
7	619A4	TUSKEGEE*	13	56	4.3	0	0	0.0
7	679	TUSCALOOSA*	67	183	2.7	0	0	0.0
		VISN 7	150	689	4.6	0	0	0.0

Appendix F
Non-MHICM Case Management Services, FY 2005
(Non-MHICM Veterans at MHICM and Non-MHICM Sites~)

SITE			MHICM Visits (Stop Code 552)			General CM Visits (Stop Code 564)		
VISN	CODE	SITE NAME	#Veterans	#Visits	MnVisits	#Veterans	#Visits	MnVisits
8	546	MIAMI*	141	268	1.9	0	0	0.0
8	548	W PALM BEACH*	1	1	1.0	1	1	1.0
8	573	N FL/S GA HCS*	51	173	3.4	0	0	0.0
8	672	SAN JUAN PR^				38	38	1.0
8	673	TAMPA*	21	100	4.8	0	0	0.0
8	673BY	ORLANDO-SOC	17	69	4.1	0	0	0.0
		VISN 8	231	611	2.6	39	39	1.0
9	603GD	DUPONT CBOC KY	6	12	2.0	19	66	3.5
9	614	MEMPHIS*	6	8	1.3	0	0	0.0
9	626A4	VA TENNESSEE VALLEY HCS	25	77	3.1	0	0	0.0
		VISN 9	37	97	2.6	0	0	0.0
10	538	CHILLICOTHE*	17	99	5.8	13	459	35.3
10	539	CINCINNATI*	30	197	6.6	0	0	0.0
10	541	CLEVELAND-WADE PARK*	1	1	1.0	0	0	0.0
10	541A0	CLEVELAND-BRECKSV.	39	470	12.1	7	8	1.1
10	541GB	LORAIN CBOC	5	9	1.8	0	0	0.0
10	541GD	MANSFIELD CBOC*	9	121	13.4	24	451	18.8
10	541GF	PAINESVILLE CBOC PH	4	7	1.8	0	0	0.0
10	541GG	AKRON CBOC*	2	5	2.5	0	0	0.0
10	541GI	WARREN CBOC CLEVELAND OH	7	91	13.0	0	0	0.0
10	552	DAYTON*	9	168	18.7	0	0	0.0
10	552GA	MIDDLETOWN CBOC OH	1	2	2.0	0	0	0.0
10	552GB	LIMA CBOC OH	1	1	1.0	0	0	0.0
10	552GC	RICHMOND CBOC IN	2	3	1.5	0	0	0.0
10	552GD	SPRINGFIELD CBOC OH	5	6	1.2	0	0	0.0
10	757	COLUMBUS-IOC*	15	36	2.4	0	0	0.0
		VISN 10	147	1,216	8.3	44	918	20.9
11	506	ANN ARBOR HCS*	1	12	12.0	0	0	0.0
	515	BATTLE CREEK*	45	586	13.0	107	949	8.9
11	550	VA ILLIANA HCS DANVILLE IL*	4	177	44.3	0	0	0.0
11	550BY	PEORIA-SOC				49	883	18.0
11	553	DETROIT VAMC*	31	119	3.8	0	0	0.0
11	583	INDIANAPOLIS-10TH ST*	13	44	3.4	0	0	0.0
11	610	NORTHERN INDIANA HCS*	4	14	3.5	8	186	23.3
11	610A4	NORTHERN IN HCS				48	1,175	24.5
		VISN 11	98	952	9.7	212	3,193	15.1
12	537	VA CHICAGO HCS*	29	121	4.2	0	0	0.0
12	556	NORTH CHICAGO*	15	74	4.9	1	1	1.0
12	556GD	KENOSHA CBOC WI	3	3	1.0	0	0	0.0
12	578	HINES*	3	11	3.7	116	7,675	66.2
12	607	MADISON*	7	63	9.0	0	0	0.0
12	676	TOMAH*	6	12	2.0	0	0	0.0
12	695	MILWAUKEE*	15	88	5.9	0	0	0.0
		VISN 12	78	372	4.8	0	0	0.0
15	589A5	EKHCS-TOPEKA DIVISION KS*	48	1630	34.0	19	77	4.1
15	657A0	ST LOUIS-Jeff Bks.*	19	114	6.0	0	0	0.0
		VISN 15	67	1,744	26.0	19	77	4.1
16	520A0	GULFPORT*	15	18	1.2	0	0	0.0
16	580	HOUSTON*	14	115	8.2	0	0	0.0
16	586	JACKSON				63	256	4.1
16	598A0	N. LITTLE ROCK*	31	68	2.2	664	4,841	7.3
16	598GC	HOT SPRINGS CBOC AR	1	1	1.0	7	163	23.3
16	629	NEW ORLEANS*	12	98	8.2	0	0	0.0
		VISN 16	73	300	4.1	734	5,260	7.2

Appendix F
Non-MHICM Case Management Services, FY 2005
(Non-MHICM Veterans at MHICM and Non-MHICM Sites~)

SITE			MHICM Visits (Stop Code 552)			General CM Visits (Stop Code 564)		
VISN	CODE	SITE NAME	#Veterans	#Visits	MnVisits	#Veterans	#Visits	MnVisits
17	549	DALLAS*	30	39	1.3	0	0	0.0
17	671	SAN ANTONIO*	7	69	9.9	0	0	0.0
17	671GB	VICTORIA (OCS)	3	4	1.3	0	0	0.0
17	674A4	WACO*	42	197	4.7	0	0	0.0
		VISN 17	82	309	4	0	0	0.0
18	501	NEW MEXICO HCS*	26	71	2.7	0	0	0.0
18	644	PHOENIX*	45	285	6.3	0	0	0.0
		VISN 18	71	356	5.0	0	0	0.0
19	442	CHEYENNE	35	964	27.5	0	0	0.0
19	554	DENVER*	20	632	31.6	4	9	2.3
19	554GD	PUEBLO CBOC CO	3	45	15.0	0	0	0.0
19	554GE	COLORADO SPGS CBOC CO	15	85	5.7	0	0	0.0
19	554GG	LA JUNTA CBOC CO	6	138	23.0	0	0	0.0
19	575	GRAND JUNCTION*	16	54	3.4	0	0	0.0
19	660	SALT LAKE CITY HTHCARE*	49	153	3.1	1	1	1.0
19	666	SHERIDAN*	17	19	1.1	0	0	0.0
		VISN 19	161	2,090	13.0	5	10	2.0
20	531	BOISE*	20	62	3.1	0	0	0.0
20	648	PORTLAND*	31	253	8.2	18	285	15.8
20	653	ROSEBURG#	67	369	5.5	0	0	0.0
20	653BY	EUGENE-SOC	1	1	1.0	0	0	0.0
20	663	PUGET SOUND HCS*	49	380	7.8	0	0	0.0
20	663A4	AMERICAN LAKE*	9	37	4.1	0	0	0.0
20	668	SPOKANE WA#				99	2,201	22.2
		VISN 20	177	1,102	6.2	117	2,486	21.2
21	612GH	MCCLELLAN CBOC	3	4	1.3	0	0	0.0
21	640A0	PALO ALTO-MENLO PK*	7	7	1.0	0	0	0.0
21	640BY	SAN JOSE	11	20	1.8	0	0	0.0
21	662	SAN FRANCISCO*	1	1	1.0	0	0	0.0
21	662BU	VA COMPREHEN HMLS CTR	6	11	1.8	0	0	0.0
		VISN 21	28	43	1.5	0	0	0.0
22	593	VA SOUTHERN NEVADA HCS^				68	680	10.0
22	600	VA LONG BEACH HCS CA*	20	37	1.9	4	6	1.5
	600GC	CABRILLO CBOC	1	1	1.0	346	586	1.7
22	605	LOMA LINDA*	10	22	2.2	0	0	0.0
22	664	VA SAN DIEGO HCS CA*	26	64	2.5	0	0	0.0
22	691	GREATER LA HCS*	33	47	1.4	0	0	0.0
		VISN 22	90	171	1.9	418	1,272	3.0
23	437	FARGO				117	681	5.8
23	438	SIOUX FALLS				159	1,070	6.7
23	618	MINNEAPOLIS*	5	5	1.0	0	0	0.0
23	636	VA NEB-WESTERN IA HCS*	4	86	21.5	0	0	0.0
23	636A6	VA CPHN DES MOINES IA	7	23	3.3	0	0	0.0
23	636A7	VA CPHN KNOXVILLE IA*	21	178	8.5	0	0	0.0
23	636A8	VA CPHN IOWA CITY IA*	6	64	10.7	0	0	0.0
23	656	ST CLOUD*	10	151	15.1	11	97	8.8
		VISN 23	53	507	9.6	287	1,848	6.4
		ALL SUM/MEAN	2,458	17,786	7.2	2,605	19,221	7.4
		VISN Mean	117	847	7.1	124	915	4.7
		Standard Deviation	64.0	858.2	6.2	186.2	1348.7	6.7
		Coefficient of Variation	0.5	1.0	0.9	1.5	1.5	1.4

~ Non-MHICM veterans were identified through VHA Automated databases in Austin, Texas.

* MHICM team operational during in FY 2005. # MHICM team not operational in FY 2005.

^ MHICM team in development during FY 2005.

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Appendix G
MHICM Complex VERA Veterans, FY 2005

This table presents numbers and proportions of veterans added to the Complex Care VERA reimbursement class due to participation in MHICM. To attain this reimbursement status, veterans must be registered in MHICM and receive 41 or more MHICM clinic stops (visits) during the fiscal year. These criteria are monitored by VHA's Allocation Resource Center (ARC) and the Northeast Program Evaluation Center (NEPEC). For FY 2005, VERA reimbursement for a veteran in the VERA MHICM Complex Care Patient Class was set at \$33,043 per year.

VISN	Site Code	Site Name	MHICM Veterans FY 2005 #	MHICM Complex^ VERA Veterans #	MHICM Complex VERA Veterans %	CMI Complex- VERA Veterans #	CMI Complex VERA Veterans %	Total Complex VERA Veterans
1	518	Bedford	142	89	62.7%	35	24.6%	87.3%
1	523A5	Brockton	80	54	67.5%	19	23.8%	91.3%
1	402	Togus	35	20	57.1%	10	28.6%	85.7%
1	689	West Haven	67	49	73.1%	11	16.4%	89.6%
		VISN 1	324	212	65.4%	75	23.1%	88.6%
2	528A8	Albany	53	33	62.3%	8	15.1%	77.4%
2	528	Buffalo	92	26	28.3%	34	37.0%	65.2%
2	528A5	Canandaigua	103	59	57.3%	27	26.2%	83.5%
2	528A7	Syracuse	52	20	38.5%	19	36.5%	75.0%
		VISN 2	300	138	46.0%	88	29.3%	75.3%
3	630A4	Brooklyn	60	12	20.0%	31	51.7%	71.7%
3	620	Hudson Valley	90	72	80.0%	10	11.1%	91.1%
3	561A4	New Jersey	95	55	57.9%	30	31.6%	89.5%
3	632	Northport	114	52	45.6%	55	48.2%	93.9%
		VISN 3	359	191	53.2%	126	35.1%	88.3%
4	542	Coatesville	107	59	55.1%	32	29.9%	85.0%
4	595	Lebanon	21	13	61.9%	5	23.8%	85.7%
4	642	Philadelphia	35	20	57.1%	6	17.1%	74.3%
4	646A5	Pittsburgh	132	51	38.6%	68	51.5%	90.2%
		VISN 4	295	143	48.5%	111	37.6%	86.1%
5	512	Baltimore	27	14	51.9%	11	40.7%	92.6%
5	613	Martinsburg	49	17	34.7%	18	36.7%	71.4%
5	512A5	Perry Point	71	50	70.4%	17	23.9%	94.4%
5	688	Washington, DC	50	16	32.0%	20	40.0%	72.0%
		VISN 5	197	97	49.2%	66	33.5%	82.7%
6	590	Fayetteville, NC	35	24	68.6%	4	11.4%	80.0%
6	658	Hampton	62	43	69.4%	12	19.4%	88.7%
6	658	Salem	38	12	31.6%	20	52.6%	84.2%
6	659	Salisbury	63	28	44.4%	28	44.4%	88.9%
		VISN 6	198	107	54.0%	64	32.3%	86.4%
7	508	Atlanta	70	49	70.0%	9	12.9%	82.9%
7	509	Augusta	78	53	67.9%	16	20.5%	88.5%
7	521	Birmingham	39	31	79.5%	6	15.4%	94.9%
7	534	Charleston	36	26	72.2%	6	16.7%	88.9%
7	544	Columbia	56	22	39.3%	14	25.0%	64.3%
7	679	Tuscaloosa	74	48	64.9%	21	28.4%	93.2%
7	619A4	Tuskegee	61	38	62.3%	20	32.8%	95.1%
		VISN 7	414	267	64.5%	92	22.2%	86.7%
8	573	Gainesville	58	48	82.8%	9	15.5%	98.3%
8	546	Miami	88	45	51.1%	13	14.8%	65.9%
8	546	Tampa	57	32	56.1%	14	24.6%	80.7%
8	548	West Palm Beach	24	11	45.8%	6	25.0%	70.8%
		VISN 8	227	136	59.9%	42	18.5%	78.4%
10	541GG	Akron	43	27	62.8%	9	20.9%	83.7%
10	538	Chillicothe	113	64	56.6%	15	13.3%	69.9%
10	539	Cincinnati	148	91	61.5%	41	27.7%	89.2%
10	541	Cleveland	143	83	58.0%	25	17.5%	75.5%
10	757	Columbus	29	20	69.0%	1	3.4%	72.4%
10	552	Dayton	127	100	78.7%	6	4.7%	83.5%
10	541GD	Mansfield	40	22	55.0%	7	17.5%	72.5%
10	541B2	Youngstown	46	33	71.7%	1	2.2%	73.9%
		VISN 10	689	440	63.9%	105	15.2%	79.1%
11	506	Ann Arbor	54	27	50.0%	17	31.5%	81.5%
11	515	Battle Creek	79	47	59.5%	26	32.9%	92.4%
11	550	Danville	42	28	66.7%	6	14.3%	81.0%
11	553	Detroit	87	31	35.6%	43	49.4%	85.1%
11	610	Northern Indiana	84	67	79.8%	12	14.3%	94.0%
		VISN 11	346	200	57.8%	104	30.1%	87.9%
12	537	Chicago West Side	73	50	68.5%	21	28.8%	97.3%
12	607	Madison	50	43	86.0%	6	12.0%	98.0%

VISN	Site Code	Site Name	MHICM Veterans FY 2005 #	MHICM Complex^ VERA Veterans #	MHICM Complex VERA Veterans %	CMI Complex~ VERA Veterans #	CMI Complex VERA Veterans %	Total Complex VERA Veterans
12	695	Milwaukee	53	31	58.5%	9	17.0%	75.5%
12	556	North Chicago	134	77	57.5%	43	32.1%	89.6%
12	676	Tomah	52	32	61.5%	9	17.3%	78.8%
		VISN 12	362	233	64.4%	88	24.3%	88.7%
15	657A0	ST. Louis	67	30	44.8%	18	26.9%	71.6%
15	589A5	Topeka	103	70	68.0%	20	19.4%	87.4%
		VISN 15	170	100	58.8%	38	22.4%	81.2%
16	520	Gulf Coast	52	12	23.1%	31	59.6%	82.7%
16	580	Houston	69	48	69.6%	16	23.2%	92.8%
16	598	Little Rock	58	38	65.5%	17	29.3%	94.8%
16	629	New Orleans	59	22	37.3%	22	37.3%	74.6%
		VISN 16	238	120	50.4%	86	36.1%	86.6%
17	549	Dallas	82	62	75.6%	18	22.0%	97.6%
17	671	San Antonio	38	28	73.7%	6	15.8%	89.5%
17	685	Waco	73	38	52.1%	25	34.2%	86.3%
		VISN 17	193	128	66.3%	49	25.4%	91.7%
18	501	Albuquerque	74	60	81.1%	8	10.8%	91.9%
18	644	Phoenix	105	37	35.2%	25	23.8%	59.0%
		VISN 18	179	97	54.2%	33	18.4%	72.6%
19	554	Denver	76	41	53.9%	31	40.8%	94.7%
19	436	Fort Harrison	51	0	0.0%	11	21.6%	21.6%
19	575	Grand Junction	45	26	57.8%	10	22.2%	80.0%
19	660	Salt Lake City	70	44	62.9%	15	21.4%	84.3%
19	666	Sheridan	18	11	61.1%	6	33.3%	94.4%
19	567	Southern Colorado	93	66	71.0%	10	10.8%	81.7%
		VISN 19	353	188	53.3%	83	23.5%	76.8%
20	663A4	American Lake	54	35	64.8%	14	25.9%	90.7%
20	531	Boise	40	1	2.5%	24	60.0%	62.5%
20	648	Portland	81	56	69.1%	18	22.2%	91.4%
20	663	Seattle	63	27	42.9%	22	34.9%	77.8%
		VISN 20	238	119	50.0%	78	32.8%	82.8%
21	640	Palo Alto	74	31	41.9%	36	48.6%	90.5%
21	662	San Francisco	46	35	76.1%	11	23.9%	100.0%
		VISN 21	120	66	55.0%	47	39.2%	94.2%
22	691	Greater Los Angeles	69	31	44.9%	26	37.7%	82.6%
22	600	Long Beach	49	34	69.4%	10	20.4%	89.8%
22	664	San Diego	76	40	52.6%	23	30.3%	82.9%
		VISN 22	194	105	54.1%	59	30.4%	84.5%
23	636A8	Iowa City	52	31	59.6%	11	21.2%	80.8%
23	636A7	Knoxville	89	46	51.7%	31	34.8%	86.5%
23	618	Minneapolis	70	39	55.7%	28	40.0%	95.7%
23	636	Omaha	48	26	54.2%	12	25.0%	79.2%
23	656	St. Cloud	41	12	29.3%	19	46.3%	75.6%
		VISN 23	300	154	51.3%	101	33.7%	85.0%
ALL SUM/MEAN			5,696	3,241	56.9%	1,535	26.9%	83.8%
84		VISN Mean	271	154	56.0%	73	28.2%	84.2%
		Standard Deviation	121.1	81.6	6.1%	25.7	6.8%	5.4%
		Coefficient of Variation	0.4	0.5	0.1	0.4	0.2	0.1

^MHICM veterans with 41 or more MHICM visits (Clinic Stop 552) during FY 2005.

~MHICM veterans assigned to Chronic Mental Illness (CMI) Patient Class based on diagnosis (Schizophrenia or Dementia or Other Psychosis) and prior service use.

Source: Allocation Resource Center; NEPEC Monitoring files.

Appendix H

MHICM Program Monitor Trends, FY 1997-2005

<u>Team Structure</u>	1997	2002	2003	2004	2005	% change 2004-1997
Teams*	40	72	74	78	84	110%
Clients^	2,021	3,566	4,108	4,761	5,696	182%
Expenditures	\$12.7M	\$20.0M	\$26.7M	\$33.8M	\$40.2M	166%
Assigned FTEE	246	315	393	453	526	217%
Filled FTEE	221	283	356	415	480	117%
% Filled	90%	90%	91%	92%	91%	1%
Teams with 4.0 Clinical FTE	53%	46%	54%	51%	58%	10%
Staff detailed away PT (sites)	8%	21%	30%	16%	23%	188%
Cost/Client	\$6,049	\$5,607	\$6,509	\$7,105	\$7,052	17%
Client/Staff ratio	12.3	12.9	12.3	12.5	12.4	1%

<u>Client Characteristics (Entry)</u>	1997	2002	2003	2004	2005	% change 2005-1997
Age	49.2	49.9	50.2	50.4	50.6	3%
Minority race / ethnicity	29.1%	32.4%	33.9%	33.2%	38.8%	33%
Mean hospital days in year pre	135.4	92.3	87.9	79.6	74.5	-45%
30+ Hospital days in year pre	91.3%	76.9%	76.6%	75.1%	72.6%	-20%
2+ yrs Hospitalized in lifetime	57.9%	48.2%	46.8%	43.6%	41.1%	-29%
Psychotic diagnosis	87.0%	90.7%	90.2%	88.9%	88.5%	2%
Substance use diagnosis	25%	20%	20.8%	20.9%	20.1%	-20%
Paid employment (3yrs pre)	12.5%	11.5%	11.4%	12.5%	12.3%	-2%
Public support income	90.6%	94.8%	94.2%	94.1%	94.1%	4%

<u>MHICM Services</u>	1997	2002	2003	2004	2005	% change 2005-1997
Contacted weekly	85%	87%	87%	88%	90%	6%
Contacts/week	1.6	1.4	1.4	1.3	1.4	-13%
60% + contacts in community	78%	88%	89%	89%	90%	16%
Discharged	16%	13%	14%	16%	13%	-19%
Client-rated Alliance	31.4	39.4	39.6	39.8	40.6	29%
Team ACT Fidelity Score	4.0	4.0	4.0	4.0	4.3	8%

<u>Client Outcome (Follow-up)</u>	1997	2002	2003	2004	2005	% change 2005-1997
BPRS Observed symptoms	-7%	-10%	-13%	-14%	-13%	86%
BSI Reported symptoms	-6%	-11%	-13%	-13%	-14%	133%
Instrumental Functioning	1%	2%	3%	3%	4%	225%
Quality of Life reported	8%	10%	10%	10%	10%	25%
Housing Independence^		13%	14%	13%	13%	2%
Satisfaction w/ MHICM (1-5)	3.7	3.7	3.7	3.7	3.7	0%
Change Inpatient days (6mos.)	-50	-35	-33	-30	-29	-42%
% Change Inpatient days (6mos.)	-64%	-72%	-72%	-71%	-72%	13%

* 84 of 92 teams in operation had sufficient data to be included in the FY 2005 report.

Remaining values for this table reflect those sites.

^ Introduced in FY 1999 Report.

End of MHICM 9th National Performance Monitoring Report - FY 2005

END OF FY 2005 MHICM PERFORMANCE MONITORING REPORT